Health Care Financing

Program Statistics

Medicare and Medicaid Data Book, 1990

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations

Health Care Financing

Program Statistics

The Health Care Financing Administration (HCFA) was established to combine health financing and quality assurance programs within a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, and a variety of other health care quality assurance programs.

The mission of HCFA is to promote the timely delivery of appropriate and quality health care to the Nation's aged, disabled, and poor receiving services as beneficiaries of the Medicare and Medicaid programs. The agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality, and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

The Office of Research and Demonstrations (ORD) conducts studies and projects that demonstrate and evaluate reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. In addition, ORD examines the impact of HCFA programs on health care status, utilization, and expenditures, as well as their effect on beneficiary access to services, health care providers, and the health care industry.

The Bureau of Data Management and Strategy (BDMS) operates HCFA's statistical data systems and maintains the national Medicare statistical files. BDMS also serves as the focal point within the agency for information systems policy, planning, and data standards development.

The Office of Actuary (OACT) directs the actuarial program for HCFA and monitors national health care expenditures and prices. OACT also provides analyses on the costs of current HCFA programs and the impact of possible legislative or administrative changes in the programs.

The *Medicare and Medicaid Data Book, 1990* is the sixth edition of a report that provides an overview of the Medicare and Medicaid programs. This report presents basic data and analyses of the programs. It includes trends on enrollees, recipients, use of services, and expenditures, and describes various aspects of the two programs. It also provides lists of Medicare carriers and intermediaries, Medicaid agencies and fiscal agents, and Agency offices to call for information.

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U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
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Symbols

—	Data not available
NA	Not applicable
Z	Percentage more than 0 but less than 0.05

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Medicare and Medicaid Data Book, 1990

by Martin Ruther, Thomas W. Reilly, Herbert A. Silverman, and Deidra B. Abbott

Executive summary

This volume is the sixth in a series of descriptive statistical reports on the Medicare and Medicaid programs. Medicare data for calendar year 1986 and Medicaid data for fiscal year 1986 are presented. The volume is intended to serve as a resource for public officials, researchers, policy analysts, and consumers who have an interest in these health programs.

In Chapter 1, brief overviews of Medicare and Medicaid are provided, and information is presented on the relationship between these two programs, Federal administration of the programs, and comparative program expenditures. Medicare and Medicaid program highlights are:

- Combined Medicare and Medicaid payments may reach $186.0 billion by fiscal year 1991, according to estimates from the Office of Budget and Administration. It is estimated that Medicare benefit payments will account for $113.3 billion of the total and Medicaid payments will account for $72.7 billion. The average annual rate of increase of Medicare payments from fiscal year 1983 to fiscal year 1991 is estimated at 9.3 percent, and the rate of increase for Medicaid payments is estimated at 10.6 percent.
- Medicare inpatient hospital payments totaled $46.7 billion in calendar year 1987. These payments increased about 2.1 percent from calendar year 1986 to calendar year 1987. The relatively small size of the increase, which is about one-seventh the average annual rate of increase prevailing since the beginning of the program, is probably attributable to the Medicare prospective payment system enacted in 1983. Physician payments ($21.9 billion) rose 16.6 percent in the same period, and outpatient services ($5.8 billion) rose 14.7 percent.
- The Office of the Actuary estimated that the largest Medicaid payments in fiscal year 1987 were for intermediate care facility services ($13.0 billion), which increased 9.4 percent from fiscal year 1986 to fiscal year 1987, followed by inpatient hospital payments ($12.7 billion), up 10.7 percent, and skilled nursing facility payments ($6.0 billion), up 5.6 percent.
- In calendar year 1986, 23.1 million of the 31.7 million aged and disabled Medicare enrollees received benefits; $68.9 billion were paid on their behalf for health services. In fiscal year 1986, 22.5 million Medicaid recipients had $41.0 billion paid on their behalf.
- In calendar year 1986, the average Medicare payment per reimbursed enrollee was $2,986. The average Medicaid payment per recipient was $1,822 in fiscal year 1986.
- Almost 59 percent of all Medicare reimbursements in calendar year 1987 were for inpatient hospital care, a decrease from about 61 percent in 1986. In contrast, the emphasis in Medicaid is on long-term care, and 42.7 percent of Medicaid payments in fiscal year 1986 were for services in intermediate care facilities and skilled nursing facilities.
- Medicare enrollees were mostly aged persons, 90.7 percent of all enrollees in 1986. The aged received 88.4 percent of all reimbursements in calendar year 1986. The remainder were disabled enrollees, including persons with end stage renal disease.
- The largest proportion of Medicaid recipients were children and adults who became eligible through provisions related to low-income families with dependent children. This group comprised 69.9 percent of all recipients but received only 24.4 percent of all payments in fiscal year 1986.

Trends in the evolution of the Medicare and Medicaid programs are reported in Chapter 2. Trends are described for the number of Medicare enrollees and Medicaid recipients, Medicare and Medicaid expenditures, and the use of and expenditures for hospital inpatient and physicians' services in both programs. Trend data are also presented for other services in each program, including Medicaid long-term care utilization and expenditures. A time series of Medicare deductibles and coinsurance amounts is presented. The chapter ends with a discussion of Medicare and Medicaid expenditures as related to national personal health care expenditures. Highlights of Medicare and Medicaid program trends are:

- From 1966 to 1986, the number of Medicare enrollees (including the disabled after coverage for them began in July 1973) increased at an average annual rate of 2.6 percent. The average age of aged Medicare enrollees also increased. The proportion of enrollees 75 years of age or over grew faster than the proportion 65-74 years of age. This gradual aging has long-term effects because older enrollees are higher users of health care services and raise the average amount reimbursed per enrollee.
- From fiscal year 1973 to fiscal year 1986, the number of Medicaid recipients increased at an average annual rate of growth of 1.1 percent per year. This overall upward trend included periods of both growth and decline.
- Total Medicare benefit payments grew 15.3 percent per year from 1967 to 1986.
- Total Medicaid payments increased at an average annual rate of 12.7 percent from 1973 to 1986.
- From 1967 to 1984, Medicare reimbursements for inpatient hospital services increased from 62.7 percent to 65.1 percent of total reimbursements, but by 1986 this share decreased to 61.4 percent. The proportion of reimbursements for skilled nursing facility services decreased from 6.5 percent in 1967 to 0.7 percent in 1986.

- Among aged persons enrolled in Medicare at any time during 1986, persons reimbursed $15,000 or more represented only 3.1 percent of the enrollees but accounted for 38.0 percent of Medicare reimbursements for the aged.
- Among disabled persons enrolled in Medicare at any time during 1986, 4.8 percent were reimbursed $15,000 or more, and this group accounted for 54.7 percent of all Medicare reimbursements for the disabled. At the other extreme, 38.0 percent of the disabled enrollees received no reimbursement.
- In fiscal year 1986, aged, blind, and disabled persons comprised 28.1 percent of all Medicaid recipients but accounted for 73.2 percent of all Medicaid payments. Children eligible under provisions related to low income families with dependent children accounted for 44.5 percent of all Medicaid recipients but only 12.5 percent of all Medicaid payments.
- According to the Medicare archival reimbursement abstract, in 1974, the first full year of Medicare coverage for patients with end stage renal disease (ESRD), reimbursements for ESRD enrollees were $240 million. By 1986, reimbursements for ESRD patients were $2.5 billion, an average annual increase of 21.5 percent.
- Reimbursements per ESRD enrollee rose from $15,000 in 1974 to $21,264 in 1986, an annual growth rate of 3.0 percent. The low rate of increase is largely attributable to limits placed on charges for kidney dialysis treatments and the increasing success of transplantation. Patients with a functioning kidney graft incur considerably lower medical expenses than those on dialysis.
- In 1978, only 11 percent of the Medicare ESRD population had a functioning kidney graft. By 1986, the comparable figure was 20 percent.
- Medicare enrollees paid $4.2 billion in hospital insurance (HI) cost sharing (deductibles and coinsurance) and $7.7 billion in supplementary medical insurance (SMI) cost sharing in calendar year 1986.
- From 1977 to 1986, HI cost sharing for aged and disabled enrollees rose at an average annual rate of 16.2 percent, and the SMI cost sharing rise averaged 13.4 percent.
- Medicare payments rose from 10.9 percent of all national personal health care expenditures in 1970 to 19.0 percent in 1985 before decreasing to 18.8 percent in 1986.
- In the same period, Medicaid payments increased at a slower rate, from 8.0 percent of national personal health care expenditures in 1970 to 10.8 percent in 1986.

In Chapter 3, the major characteristics of the Medicare program are described and program statistics are presented on Medicare eligibility, benefits, financing, and administration. The data include separate tabulations for the aged and disabled Medicare beneficiaries. The chapter concludes with a description of Medicare's arrangements with group health plans and a discussion of the Medicare statistical system. Highlights from Chapter 3 are:

Persons served and reimbursement per person, 1986

- Much larger proportions of aged and disabled enrollees received SMI benefits than HI benefits. However, for both groups, average payments per person served were far higher for HI services than for SMI services.
- For each category of services, the proportion of aged enrollees receiving Medicare benefits was successively higher for older age groups. By far the largest proportion of aged enrollees used physicians' services, followed by outpatient and then inpatient hospital services.
- Among the aged, larger proportions of white enrollees than all other races received Medicare benefits for inpatient hospital, skilled nursing facility, outpatient, and physicians' services. Larger proportions of aged enrollees of races other than white received home health services.
- For each category of service, aged persons of races other than white had higher reimbursements per person served than did white persons. However, reflecting the differences in the proportion of enrollees receiving benefits for individual services, the amount reimbursed per enrollee showed different distributions of benefits by race. White persons received higher reimbursements per enrollee for skilled nursing facility and physician services.
- A larger proportion of aged females than aged males received benefits for all services except inpatient hospital services.
- Reimbursement per aged person served was highest for inpatient hospital services ($6,536), followed by skilled nursing facility services ($1,613) and home health agency services ($1,115). Comparable figures for SMI services were $992 for physicians' services and $389 for outpatient services.

Hospital insurance benefits, 1986

- For aged enrollees, short-stay hospital discharges per 1,000 enrollees and covered days of care per 1,000 enrollees increased with age.
- Aged persons of races other than white had a higher discharge rate, longer average lengths of stay, and higher charges per discharge than did white persons.
- The proportion of aged enrollees who received skilled nursing facility (SNF) benefits was three times higher than that of the disabled.
- Among both the aged and the disabled, higher proportions of females than males received SNF benefits.

Supplementary medical insurance benefits, 1986

- Almost three-fourths of the aged enrollees (729.8 per 1,000 enrollees) received reimbursement for physicians' services. The average amount reimbursed per person served was $835. A lower proportion of the disabled received reimbursement for physicians' services (685.2 per 1,000 enrollees), but they received a higher amount of reimbursements ($992). Overall, the amount reimbursed per enrollee was higher for the disabled ($680) than for the aged ($609).
- For aged and disabled enrollees combined, Medicare carriers reduced total physicians' charges by 28.5 percent.
- Among the aged, Medicare reimbursed 67.2 percent of physicians' charges due (total charges less the reduction amount on assigned claims). The remainder, 32.8 percent, was the liability of the Medicare patients. It consisted of coinsurance, 16.8 percent; the reduction on unassigned claims, 10.0 percent; and the deductible, 6.0 percent.
- For outpatient services, both the proportion of persons reimbursed and the average reimbursement were higher for disabled than for aged enrollees. This reflected, in part, the use of dialysis services by disabled enrollees with ESRD.

Group health plans

- Prospective capitation payments provided a new incentive for group health plans to cover Medicare enrollees on an at-risk basis. As evidence of this incentive, the combined Medicare enrollment in risk plans rose 36 percent, from 781,000 in November 1986 to 1,063,000 in December 1988.

Detailed data on the Medicaid program are reported in Chapter 4. Descriptions of Medicaid program characteristics such as eligibility, service coverage and limitations, and administration and financing are presented. Statistical data are presented on service use and expenditures for each Medicaid jurisdiction. During the development of this publication, when Federal and State Medicaid data were found to differ, State data were used. Hence, the data in this publication may differ slightly from those in other Health Care Financing Administration publications. Highlights from Chapter 4 follow:

Medicaid program characteristics

- In the 1980s, there were significant Medicaid eligibility expansions, particularly for children and pregnant women. Traditional linkages to cash assistance eligibility were loosened, and additional poverty-level groups were covered.
- As of October 1989, the most frequently offered optional services, based on the number of States and territories offering them, were clinic services (54), prescribed drugs (53), and optometrists' services (52).
- The Federal share of medical vendor payments is based on State per capita income. For fiscal year 1990, 18 jurisdictions received the minimum Federal Medicaid assistance percentage of 50 percent; Mississippi, the State with the lowest per capita income, received the highest, 80.18 percent.

Medicaid service use and payments, fiscal year 1986

- There were 22.5 million Medicaid recipients in fiscal 1986, for whom payments of $41.0 billion were made for medical assistance.
- Although 69.6 percent of all recipients were in families with dependent children, they accounted for only 24.4 percent of all vendor payments.
- The aged accounted for the largest share of total vendor payments (36.8 percent) but represented only 13.9 percent of all recipients.
- The blind and disabled accounted for 36.4 percent of total payments but only 14.2 percent of total recipients.
- Females comprised 64.0 percent of all recipients and also accounted for the larger share of total vendor payments (65.5 percent).
- By far, the largest part of Medicaid payments went for long-term care services. Together, skilled nursing facility (SNF), intermediate care facility (ICF), and intermediate care facility for the mentally retarded (ICF-MR) services account for 42.7 percent of all Medicaid payments. Individually, 13.8 percent of all Medicaid payments were accounted for by the 2.5 percent of Medicaid recipients using SNF services, 16.5 percent of payments were accounted for by the 3.7 percent of recipients using ICF services, and 12.4 percent of all payments were accounted for by the 0.6 percent of recipients who used ICF-MR services. Inpatient services in general hospitals accounted for another 25.3 percent of Medicaid payments. Overall, long-term care and inpatient hospital services accounted for more than two-thirds of all Medicaid payments.

This volume contains several appendixes to help the reader understand and identify additional sources of information. Names and addresses are listed for Medicare intermediaries and carriers. Telephone numbers are supplied for Medicaid State agencies and medical assistance programs and for the Health Care Financing Administration offices responsible for various facets of the Medicare and Medicaid programs. A glossary and list of acronyms used in this report are also included.

1. Introduction to Medicare and Medicaid

In this chapter, the major characteristics of the Medicare and Medicaid programs are outlined. Information is also presented on the relationship between the two programs, including a description of coverage for persons eligible under both programs. In addition, material is provided on how much each program spends (in total and per enrollee or per recipient) in each State and how the Federal Government is organized to administer both programs.

Overview of Medicare program

The Medicare program covers hospital, physicians' and other medical services for most persons 65 years of age or over, disabled persons entitled to social security cash benefits for at least 24 months, and most persons with end stage renal disease. Major changes in the Medicare law through the Omnibus Budget Reconciliation Act of 1986 (Public law 99-509), are described in this report. Total Medicare benefit payments (reimbursements and other payments from Medicare trust funds) totaled $79.8 billion in calendar year 1987.

Medicare has two complementary but distinct parts: hospital insurance (HI), also called Part A, and supplementary medical insurance (SMI), also called Part B. The HI program covers 90 days of inpatient hospital care in a benefit period (spell or illness), which begins with the first day of hospitalization and ends when the beneficiary has not been an inpatient in a hospital or skilled nursing facility (SNF) for 60 consecutive days. There is no limit to the number of benefit periods an individual may use. The program also provides a nonrenewable (lifetime) reserve of 60 days if a beneficiary exhausts the 90 days available in a benefit period.

In addition to inpatient hospital care, the HI program covers up to 100 post-hospital days in an SNF if the beneficiary is certified to require such care. The HI program also covers home health agency visits.

About 95 percent of the Nation's aged are enrolled in the HI program. On July 1, 1966, when Medicare became operational, 19.1 million aged persons were enrolled. By July 1, 1986, the number of enrollees had increased to 31.7 million; this total included 3.0 million disabled enrollees. (Medicare coverage of the disabled began on July 1, 1973.)

Nearly everyone covered by HI voluntarily enrolls in SMI. Unlike HI, SMI requires a monthly premium payment, $24.80 per month as of January 1988 (increasing to $27.90 in 1989). Under buy-in agreements, most State Medicaid programs pay these premiums for persons who qualify for both Medicaid and Medicare benefits. The SMI program provides payments for physicians as well as related services and supplies ordered by physicians. SMI also covers outpatient hospital services, rural health clinic visits, and home health visits.

Several health care services widely used by the aged, such as routine eye examinations and preventive services, are not covered by Medicare. Drugs and certain dental procedures are covered only if provided during an authorized hospital inpatient stay. Neither intermediate nor long-term nursing care is covered by Medicare.

Both the HI and SMI programs require beneficiary cost sharing. Under HI, the patient is required to pay an inpatient hospital deductible for each benefit period. The Secretary of Health and Human Services set the annual HI deductible at $540 for 1988 based on a formula specified by law. The coinsurance amount is based on percentages of the inpatient hospital deductible. Coinsurance equal to one-fourth of the hospital deductible is required for the 61st through 90th day of inpatient hospital care; an amount equal to one-eighth of the deductible is required for the 21st through 100th day of SNF care; and an amount equal to one-half of the deductible is required for the 60 lifetime reserve days for inpatient hospital care. The patient is also liable for the cost or replacement of the first three pints of blood in a benefit period.

Under SMI, in addition to paying a monthly premium, the beneficiary must pay a $75 deductible each year. (The Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, raised the deductible from $60 to $75, effective January 1, 1982.) Physicians can accept or reject assignment. Acceptance of assignment means participating physicians agree to accept as full payment the amount Medicare allows for the service. The program reimburses 80 percent of allowed (reasonable) charges directly to the physician. Beneficiaries are liable for the remaining 20 percent of allowed charges (coinsurance). Nonparticipating physicians do not agree to accept assignment. On unassigned claims, the beneficiary is responsible for the difference between the physician's charge and the allowed charge as well as the 20-percent coinsurance. (Benefits under SMI and the participating and nonparticipating physician program are discussed in more detail in Chapter 2.) The Medicaid program assumes cost sharing for Medicaid enrollees covered under buy-in agreements. (As of December 1987, only three Medicaid jurisdictions did not have a buy-in program.) The buy-in program is discussed in more detail later in this chapter.

Medicare benefits and administrative expenses are paid from two separate trust funds. The HI trust fund is financed primarily through a tax on current earnings from employment covered by the Social Security Act. The SMI trust fund is financed through premiums paid by or on behalf of persons enrolled in the program and from general revenues of the Federal Government.

Overview of Medicaid program

Medicaid is a federally supported and State-administered assistance program providing medical care for certain low-income individuals and families. Medicaid accounted for $41.0 billion in Federal and State expenditures for medical services in fiscal year 1986.

Certain groups must be covered by State Medicaid programs. These mandatory groups generally relate to two broad categories. The first is low-income families with dependent children. Historically this group has been composed of families receiving cash assistance through the Aid to Families with Dependent Children (AFDC) program, but recent legislation has expanded Medicaid eligibility in this area to include other low-income families. The second category is low-income aged and disabled. Generally, this group includes individuals receiving cash assistance through the Supplemental Security Income (SSI) program and certain SSI-related groups. States also have the option to cover additional groups, including groups related to the mandatory coverage groups (i.e., low-income families with dependent children, low-income aged and disabled), and the medically needy. The medically needy are individuals whose incomes or resources are above levels generally required for eligibility but who have incurred large medical expenses.

Title XIX of the Social Security Act requires that every State Medicaid program offer certain basic services: inpatient hospital services, outpatient hospital services, laboratory and X-ray services, SNF services for individuals 21 years of age or over, home health services for individuals eligible for SNF services, physicians' services, family planning services, rural health clinic services, nurse-midwife services, and early and periodic screening, diagnosis, and treatment services for individuals under 21 years of age. In addition, States may elect to provide a number of other services, including prescription drugs, eyeglasses, private-duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21 years of age, physical therapy, and dental care.

Medicaid is a vendor payment program; payments are made directly to providers of service for care rendered to eligible individuals. Providers who choose to participate in the program must accept the Medicaid reimbursement levels as full payment. States have wide latitude in choosing methods of provider reimbursement.

Medicaid is financed jointly with State and Federal funds. Federal contributions vary with States' per capita income and currently range from 50 percent to 80 percent of program medical expenditures. Administrative costs are financed at other rates.

As noted earlier, by the end of 1987, most State Medicaid programs had buy-in agreements with Medicare. Under these agreements, Medicaid pays the Part B Medicare premiums and cost sharing for persons covered by both programs. Medicare, in turn, pays for the costs of Medicare-covered services for this dually enrolled population. The Medicare Catastrophic Coverage Act of 1988 (Public Law 100-234) made Medicaid buy-in of Medicare coverage mandatory for qualified Medicare beneficiaries (QMBs) as of January 1, 1989. QMBs are elderly and disabled persons whose incomes are at or below specified percentages of the Federal poverty level. This provision was retained despite subsequent repeal of major portions of the legislation.

States administer their Medicaid programs within broad Federal requirements and guidelines. These requirements allow States considerable discretion in determining income and other resource criteria for eligibility, covered benefits, and provider payment mechanisms. As a result, the characteristics of Medicaid programs vary considerably from State to State.

Comparison of Medicare and Medicaid

Data: Sources and characteristics

The marked differences in the statistical systems supporting the Medicare and Medicaid programs limit comparisons of the two programs. In this section, some differences between the data produced by the two statistical systems are discussed.

The Medicare statistical system collects data on enrollees, that is, persons eligible for Medicare. In addition, data are shown for enrollees who receive services for which reimbursements were made (referred to as persons served). In contrast, Federal Medicaid statistics currently consist of aggregate counts of the number of recipients (as opposed to enrollees) and dollars expended on covered services.

Most of the Medicare statistics in this report are produced from the Medicare statistical system, which contains the universe of claims that are processed in the Central Office of the Health Care Financing Administration (HCFA) in Baltimore. The Central Office also tabulates data on the services used by each person reimbursed. Medicaid statistics also are maintained in the Central Office, but only after they have been aggregated in recipient and expenditure counts by the States. These data are reported annually to HCFA by the Medicaid jurisdictions. Unlike most Medicare data, HCFA data on the Medicaid program cannot be disaggregated by individual person. Thus, the range of analyses is more limited for Medicaid statistics than for Medicare statistics.

Medicare claims data are generally reported for the calendar year in which medical services were rendered rather than the date when Medicare payment was made. Conversely, Medicaid recipient and expenditure counts included in the following tables were reported for the fiscal year in which services were paid. More information on the current Medicare and Medicaid data systems is contained in Chapters 3 and 4, respectively.

State buy-in coverage

Through State buy-in agreements, 3.3 million (about 10 percent) aged and disabled SMI Medicare enrollees were also covered by State Medicaid programs in calendar year 1986. States can obtain SMI coverage for these eligibles under buy-in agreements with Medicare. States that buy in pay the SMI premium and are responsible for Medicare cost sharing. When persons are eligible under both programs, Medicare is the primary payer for Medicare services, and Medicaid pays the deductible and coinsurance. State payments for the deductible and coinsurance amounts on behalf of

persons covered by the buy-in arrangements are included in the total Medicaid expenditures for which Federal contributions are made. The establishment of the rate of the Federal contribution ("matching") is discussed in Chapter 4. Although States may buy into Medicare for any of their Medicare-Medicaid eligibles, they receive Federal funds on premium payments only for the categorically needy . States must pay the full cost of premium payments for other Medicaid eligibles.

If a State does not buy SMI coverage for Medicare-Medicaid eligibles, it cannot receive Federal payments for services that would have been covered under SMI. All but one State and two other jurisdictions with Medicaid programs (Wyoming, Puerto Rico, and the Northern Marianas) had buy-in arrangements as of calendar year 1987. Beginning January 1, 1989, all States were required to provide Medicaid buy-in of Medicare coverage for QMBs. Such coverage of QMBs is optional for commonwealths and territories.

State Medicaid programs provide many services for the aged and disabled that are not provided by Medicare, including SNF care beyond the 100-day post-hospital benefit provided by Medicare, long-term care in intermediate care facilities (ICFs), prescription drugs, eyeglasses, and hearing aids. In terms of the range of benefits that a State may provide, Medicaid is more comprehensive than Medicare. However, States have broad flexibility to define limits on the amount, duration, and scope of the services they cover.

Medicare and Medicaid expenditures

Total program payments—Medicare benefit payments and Medicaid assistance payments—for fiscal years 1983-91 are shown in Table 1.1. The data for 1989-91 are estimates from HCFA's Office of Budget and Administration (OBA) assuming that current law continues during this time period. OBA estimated that payments for Medicare and Medicaid combined will increase from $88.0 billion in fiscal year 1983 to $186.0 billion in fiscal year 1991. In fiscal year 1991, Medicare benefit payments may total $113.3 billion and Medicaid assistance may reach $72.7 billion. The average annual rate of change, according to OBA, may be an increase of 9.3 percent for Medicare payments and 10.6 percent for Medicaid payments.

Office of the Actuary (OACT) preliminary estimates of Medicare and Medicaid payments by type of service are shown in Table 1.2. OACT estimated that Medicare trust fund benefit payments increased 7.7 percent from calendar year 1986 to calendar year 1987. The largest payments were for inpatient hospital services, which increased only 2.1 percent. This relatively low rate of increase was probably the result of the Medicare prospective payment system which went into effect in 1983 and based Medicare payments on pre-established rates for specific diagnoses and procedures, called diagnosis-related groups (DRGs). This system replaced the previous system whereby Medicare payments were retrospectively based on the hospital's incurred costs, a system which offered little incentive to control costs.

Table 1.1
Medicare benefit payments and Medicaid payments: Fiscal years 1983-91

Fiscal year	Total	Medicare benefit payments	Medicaid payments[1]
		Amount in billions	
1983	$88.0	$55.6	$32.4
1984	94.8	60.9	33.9
1985	107.0	69.5	37.5
1986	115.0	74.0	41.0
1987	125.0	79.8	45.2
1988	136.4	85.5	50.9
1989	148.9	94.2	54.7
1990	171.6	[2]105.4	66.2
1991	186.0	113.3	72.7
		Percent	
ACRG[3]	9.8	9.3	10.6

[1] Includes Federal and State shares.
[2] Includes applicable provisions under the Catastrophic Coverage Act of 1988 in effect fiscal years 1989 and 1990.
[3] Annual compound rate of growth.

SOURCES: 1983-87 data: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates. 1988-91 data: Office of Budget and Administration estimates assuming current law.

Next in size were payments for physicians' services which rose 16.6 percent, followed by payments for outpatient services which increased 14.7 percent. OACT estimated that Medicaid payments rose 10.1 percent from fiscal year 1986 to fiscal year 1987. The largest payments were for ICF services which increased 9.4 percent. Next in size were payments for inpatient hospital services, up 10.7 percent, followed by SNF payments, up 5.6 percent.

Medicare and Medicaid population and expenditures

In Table 1.3, Medicare and Medicaid population data and expenditures are compared. In calendar year 1986, 23.1 million (72.6 percent) of the 31.7 million aged and disabled persons enrolled in Medicare received Medicare-covered benefits. In fiscal year 1986, 22.5 million persons received health services paid by Medicaid. About one-quarter of all persons served under the Medicare program resided in California, Florida, or New York. For Medicaid, the three States with the largest number of recipients in fiscal year 1986 were California, New York, and Michigan, which together accounted for 30.7 percent of all Medicaid recipients.

In calendar year 1986, Medicare reimbursements rose to $68.9 billion; in fiscal year 1986, $41.0 billion was spent on behalf of Medicaid recipients. Medicare reimbursements in calendar year 1986 were largest for California residents ($7.9 billion). Reimbursements for residents of New York ($5.5 billion), Pennsylvania ($4.9 billion), and Florida ($4.6 billion) were next in size. Together, these four States accounted for 33.2 percent of total Medicare reimbursements. Payments for Medicaid recipients in fiscal year 1986 were largest in New York ($8.2 billion), California ($4.4 billion), Ohio ($2.0 billion), Pennsylvania ($2.0 billion), and Michigan ($1.8 billion). These five States

Table 1.2

Medicare benefit payments in calendar years 1986-87 and Medicaid payments in fiscal years 1986-87, by type of service

Type of service	Medicare benefit payments			Medicaid payments		
	Amount in millions		Percent change	Amounts in millions		Percent change
	1986	1987	1986-87	1986	1987	1986-87
Total	$74,036	$79,750	7.7	$41,027	$45,170	10.1
Inpatient hospital	45,754	46,701	2.1	11,481	12,705	10.7
Physician	18,800	21,920	16.6	2,548	2,779	9.1
Outpatient	5,049	5,793	14.7	1,983	2,226	12.3
Skilled nursing facility[1]	607	592	-0.2	5,656	5,975	5.6
Intermediate care facility (ICF)	NA	NA	NA	11,861	12,979	9.4
ICF/MR[2]	NA	NA	NA	5,081	5,659	11.4
ICF, all other	NA	NA	NA	6,780	7,320	8.0
Home health agency	2,503	2,492	Z	1,352	1,697	25.5
Group health plan	705	1,336	89.5	—	—	—
Prescribed drugs	NA	NA	NA	2,692	2,999	11.4
Other[3]	618	916	48.2	3,454	3,810	10.3

[1] Hospices included in Medicare skilled nursing facility counts.
[2] Intermediate care facility for the mentally retarded.
[3] For Medicare: Independent laboratory. For Medicaid; Dental; other practioners'; laboratory and radiological services; family planning; clinic; early and periodic screening, diagnosis, and treatment; and other care services.

NOTE: Data are preliminary.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

Table 1.3

Medicare enrollees, persons served, and reimbursements in calendar year 1986 and Medicaid recipients and payments in fiscal year 1986, by area

Area[1]	Medicare		Medicaid recipients in thousands	Medicare reimbursements in millions[3]	Medicaid payments in millions	Medicare reimbursement per person served[3]	Medicaid payment per recipient
	Enrollees in thousands[2]	Persons served in thousands					
All areas	31,749.7	23,059.7	22,517.7	$68,862.9	$41,027.3	$2,986	$1,822
United States	31,090.2	22,897.5	20,742.0	68,659.3	40,867.3	2,999	1,970
Alabama	543.3	415.5	316.4	1,157.6	409.6	2,786	1,295
Alaska	19.0	13.0	28.7	48.1	85.1	3,712	2,965
Arizona[4]	426.1	312.2	NA	956.1	NA	3,062	NA
Arkansas	372.4	271.1	203.3	708.0	433.9	2,612	2,134
California	3,011.7	2,216.0	3,466.1	7,931.6	4,405.2	3,579	1,271
Colorado	313.5	223.5	149.0	638.8	300.2	2,858	2,014
Connecticut	443.6	341.2	216.6	938.6	675.3	2,751	3,117
Delaware	79.0	62.3	39.3	182.8	79.1	2,932	2,014
District of Columbia	78.7	59.5	98.0	241.6	201.3	4,061	2,053
Florida	2,068.3	1,555.1	587.6	4,559.3	1,003.3	2,932	1,707
Georgia	668.4	499.2	483.5	1,394.3	818.1	2,793	1,692
Hawaii	107.6	75.5	88.9	185.3	136.7	2,455	1,537
Idaho	120.1	89.3	40.3	204.1	85.5	2,287	2,121
Illinois	1,461.4	1,022.9	1,063.5	3,631.5	1,675.0	3,550	1,575
Indiana	710.8	498.2	297.8	1,404.2	828.4	2,818	2,782
Iowa	440.3	322.0	221.9	766.6	374.4	2,381	1,687
Kansas	347.3	262.4	131.0	715.1	238.5	2,725	1,820
Kentucky	501.5	350.0	414.9	954.3	536.6	2,726	1,293
Lousiana	493.6	339.1	446.4	1,209.6	779.6	3,567	1,746
Maine	172.1	135.1	125.1	305.7	282.8	2,263	2,261
Maryland	493.0	377.2	323.4	1,224.7	680.0	3,247	2,103
Massachusetts	834.6	631.9	528.9	2,010.4	1,664.8	3,182	3,148
Michigan	1,150.0	926.1	1,119.7	2,875.3	1,767.8	3,105	1,579
Minnesota	556.7	321.4	344.5	804.9	1,044.4	2,505	3,032
Mississippi	348.6	248.8	318.9	674.1	316.6	2,710	993
Missouri	744.9	542.0	359.9	1,737.6	555.8	3,206	1,544
Montana	108.0	74.8	52.2	192.1	112.0	2,568	2,145
Nebraska	229.3	151.9	102.1	355.4	187.5	2,340	1,838
Nevada	106.5	68.2	32.5	238.2	79.2	3,494	2,435
New Hampshire	127.3	95.1	35.3	234.0	133.1	2,460	3,765

See footnotes at end of table.

Table 1.3—Continued

Medicare enrollees, persons served, and reimbursements in calendar year 1986 and Medicaid recipients and payments in fiscal year 1986, by area

Area[1]	Medicare		Medicaid	Medicare	Medicaid	Medicare	Medicaid
	Enrollees in thousands[2]	Persons served in thousands	recipients in thousands	reimbursements in millions[3]	payments in millions	reimbursement per person served[3]	payment per recipient
New Jersey	1,039.4	789.1	581.2	2,394.5	1,281.4	3,035	2,205
New Mexico	156.1	104.7	91.8	283.4	164.8	2,706	1,794
New York	2,446.0	1,885.9	2,322.6	5,474.4	8,223.3	2,903	3,541
North Carolina	797.9	583.5	378.2	1,283.1	750.8	2,199	1,985
North Dakota	94.3	71.9	40.1	187.9	121.7	2,613	3,030
Ohio	1,438.0	1,071.4	1,078.9	3,352.6	2,049.5	3,129	1,900
Oklahoma	426.2	301.6	242.3	820.4	422.3	2,721	1,743
Oregon	383.9	268.8	162.5	593.6	260.4	2,209	1,602
Pennsylvania	1,849.5	1,446.3	1,099.3	4,926.9	1,992.8	3,407	1,813
Rhode Island	152.1	123.7	97.2	340.9	262.7	2,756	2,703
South Carolina	392.6	271.6	262.1	668.1	393.8	2,460	1,502
South Dakota	104.9	74.6	36.7	184.5	102.9	2,473	2,809
Tennessee	641.4	453.2	394.7	1,374.6	714.4	3,033	1,810
Texas	1,643.4	1,164.7	879.0	3,579.4	1,628.4	3,073	1,853
Utah	140.2	101.2	75.6	249.2	140.3	2,461	1,855
Vermont	70.4	54.2	50.0	124.7	94.6	2,303	1,891
Virginia	651.9	484.3	314.2	1,327.5	594.6	2,741	1,892
Washington	551.0	401.3	357.9	1,029.8	625.4	2,566	1,748
West Virginia	292.8	206.7	211.2	562.4	200.8	2,721	951
Wisconsin	673.9	504.8	409.4	1,327.2	919.7	2,629	2,246
Wyoming	46.0	31.6	21.0	90.0	32.8	2,846	1,563
State unknown	20.7	1.8	NA	4.3	NA	2,415	NA
U.S. territories and possessions[5]	407.8	154.3	1,775.7	179.3	160.0	1,162	90
Guam	3.3	1.4	—	3.7	—	2,548	—
Puerto Rico	398.2	150.8	1,761.8	172.2	155.9	1,142	89
Virgin Islands	6.3	2.1	13.9	3.4	4.1	1,654	294
Foreign countries	250.4	8.0	NA	24.0	NA	3,010	NA

[1] For Medicare, area of enrollee; for Medicaid, area of provider of medical services.
[2] As of July 1, 1986.
[3] Hospital insurance reimbursement amounts are based on expenditures reported on Health Care Financing Administration (HCFA) billing form HCFA-1450 plus prospective payment system short-stay hospital inpatient passthrough expenditures reported on the HCFA intermediary benefit payment report.
[4] Arizona does not have a Medicaid program.
[5] Includes all other outlying areas.

NOTES: Medicare data are for services rendered during calendar year 1986; Medicaid data are for services paid for during fiscal year 1986.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

accounted for 45 percent of total Medicaid expenditures.

The average Medicare reimbursement per person served was $2,986 in calendar year 1986. The average payment per Medicaid recipient was $1,822 in fiscal year 1986. Medicare enrollees in the District of Columbia had the largest reimbursement per person served ($4,061), with total reimbursements of $241.6 million. Next in size were Alaska ($3,712 per person served), with total reimbursements of $48.1 million, and California ($3,579 per person served), with total reimbursements of $7.9 billion. Payments per Medicaid recipient in fiscal year 1986 were highest in New Hampshire ($3,765), with total payments of $133.1 million. Next were New York ($3,541 per recipient) and total payments of $8.2 billion, followed by Massachusetts ($3,148) and $1.7 billion in total payments.

Several important differences between Medicare and Medicaid are illustrated in Figures 1.1 through 1.3. As shown in Figure 1.1, Medicare is oriented toward acute care services, consistent with its statute. Inpatient hospital care accounted for 61.4 percent of total Medicare reimbursements (i.e., HI and SMI combined) in 1986. Less than 1 percent (0.7) of Medicare reimbursements went to SNFs, where coverage is limited to short-term post-hospital recuperative or rehabilitative care. In contrast, as shown in Figure 1.2, inpatient hospital services absorbed only 28.0 percent of total Medicaid payments in fiscal year 1986, while payments for long-term care in nursing homes, both ICFs and SNFs made up 42.8 percent of total Medicaid payments.

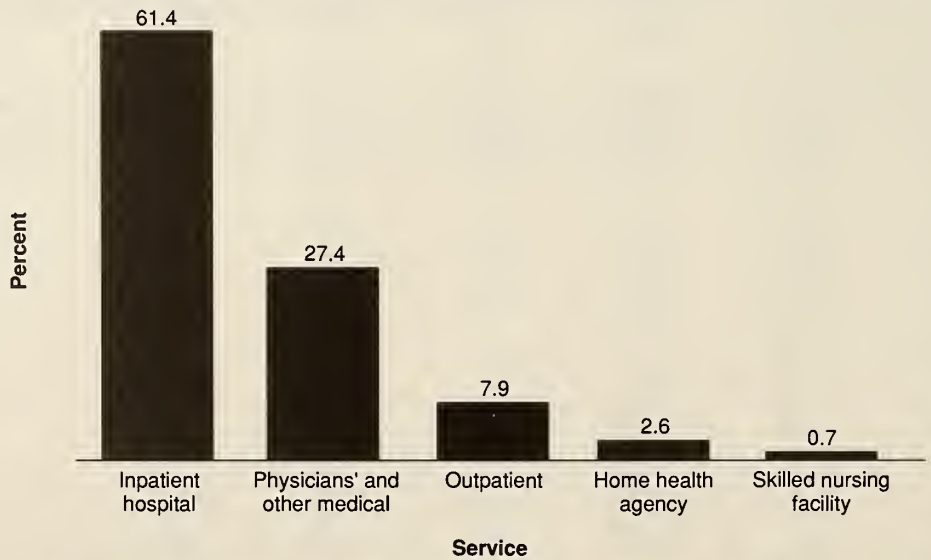
Medicare and Medicaid also differ in the relative size and distribution of reimbursements among their enrollee and eligibility groups. As shown in Figure 1.3, Medicare serves predominantly the aged, who comprised 90.7 percent of all enrollees and received 88.3 percent of all reimbursements. Medicaid aged, blind, and disabled made up 28.1 percent of all recipients but were responsible for 73.2 percent of all payments. In contrast, children and adults eligible through provisions related to families with dependent children made up 69.6 percent of all Medicaid recipients but accounted for only 24.4 percent of total payments.

Program administration

Medicare and Medicaid were administered by separate agencies in the Department of Health, Education, and Welfare from 1965 to 1977. In 1977, these agencies were merged into the Health Care Financing Administration within the Department of Health and Human Services. Under that structure, the operation of Medicare and Medicaid was combined, with each newly created bureau or office dealing with a specific aspect of both programs. An intermediate level of associate administrators was added in 1981. The four associate administrators and the four staff offices shown in Figure 1.4 report to the Administrator and the Deputy Administrator.

Figure 1.1

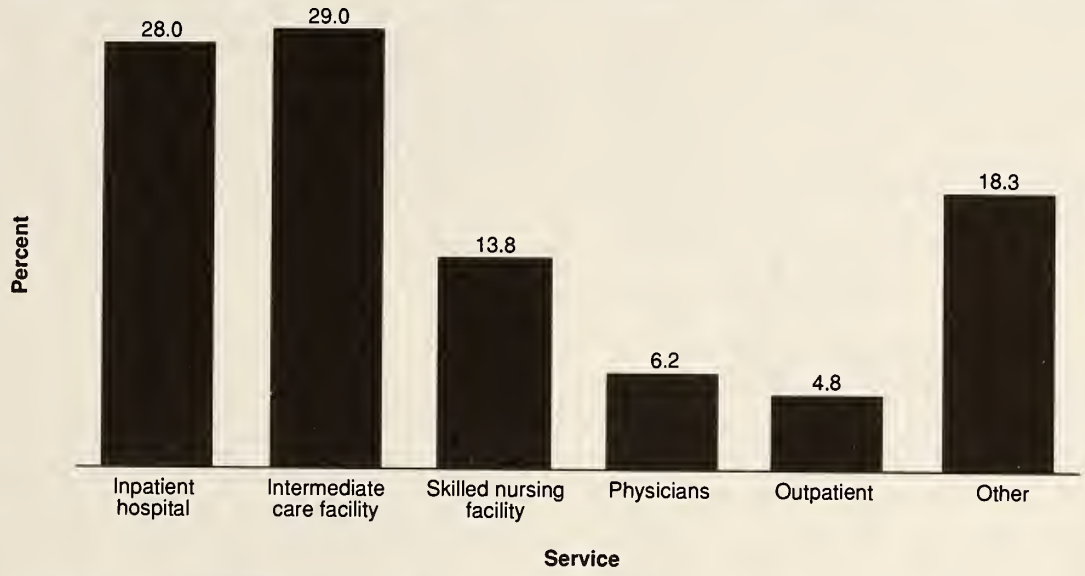
Percent distribution of Medicare reimbursements, by type of service: Calendar year 1986



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 1.2

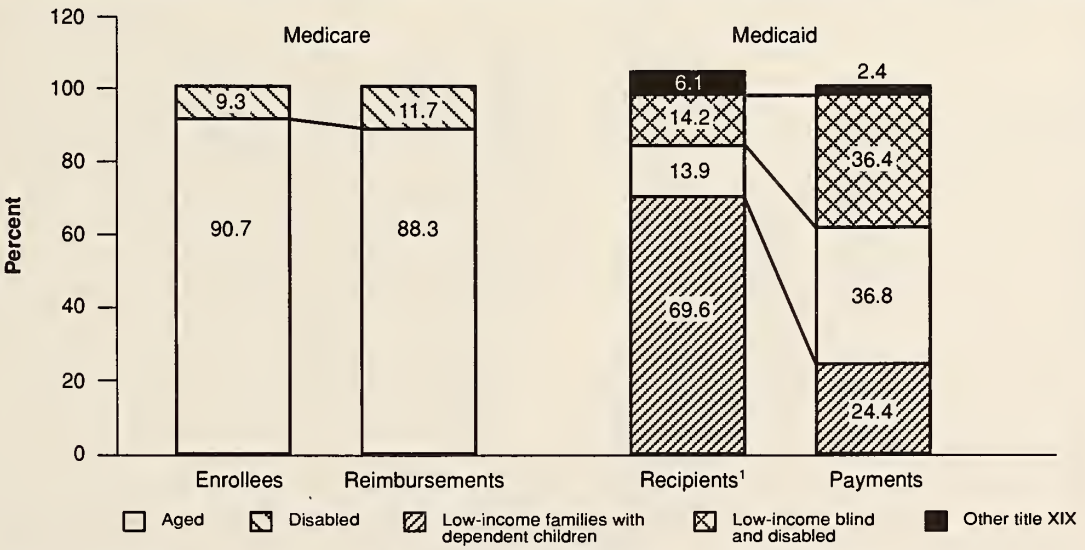
Percent distribution of Medicaid payments, by type of service: Fiscal year 1986



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 1.3

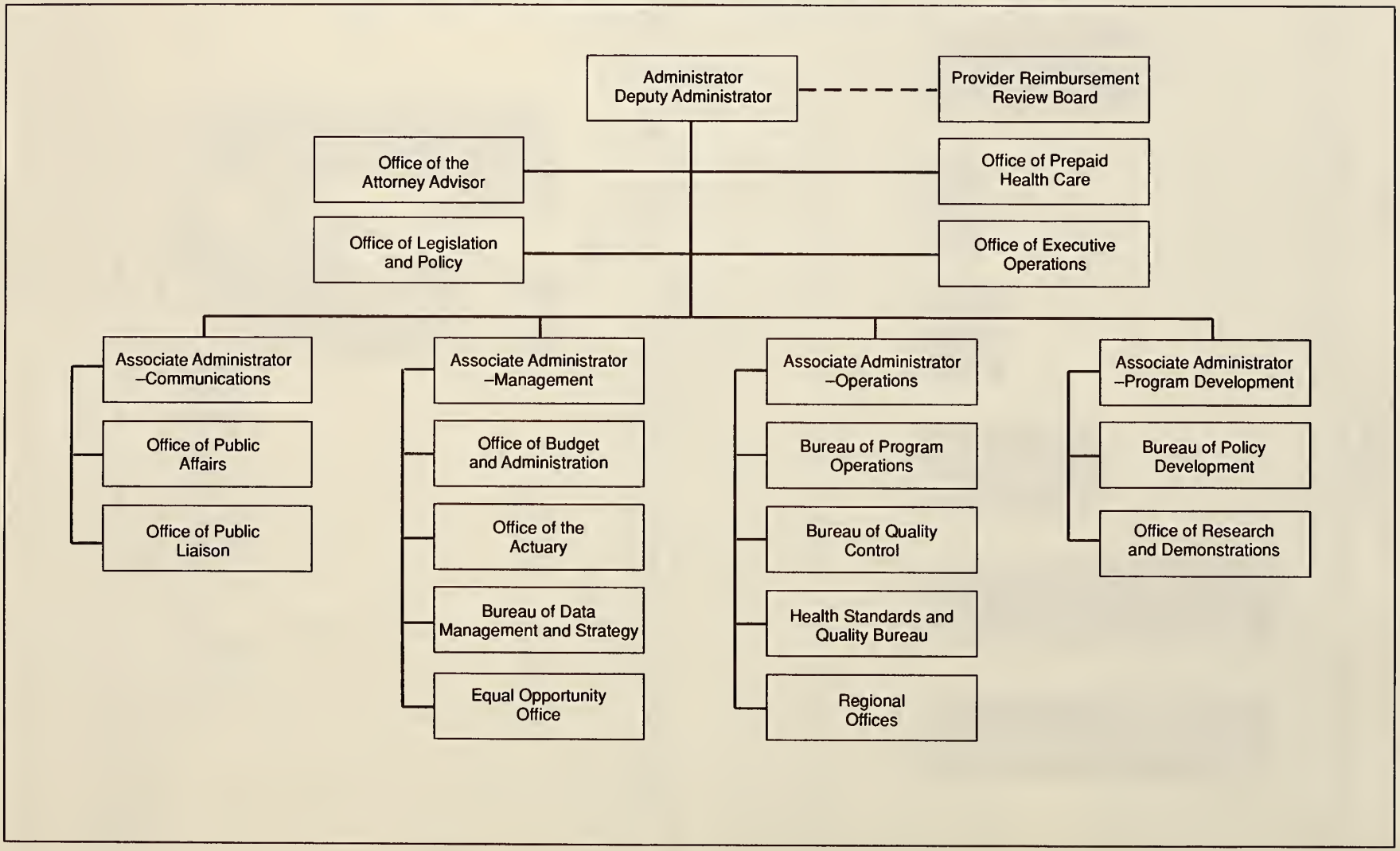
Percent distribution of Medicare enrollees and reimbursements, by type of enrollee in calendar year 1986 and Medicaid recipients and payments, by basis of eligibility in fiscal year 1986



[1]The sum of percentages by basis of eligibility exceeds 100 percent bacause a recipient may be counted in more than one eligibility group.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 1.4
Health Care Financing Administration organizational chart: October 1989



2. Medicare and Medicaid trends

In this chapter, trends in the Medicare and Medicaid programs are reported: the number of Medicare enrollees and Medicaid recipients by basis of eligibility and population characteristics; expenditures, in total and by eligibility category; and hospital inpatient services, physicians' services, and other services financed by the Medicare and Medicaid programs. Changes in the Medicare deductibles and coinsurance amounts since the beginning of the program are described. The chapter ends with a discussion of Medicare and Medicaid expenditures as related to national personal health care expenditures.

Enrollees and recipients

As shown in Table 2.1, the number of Medicare enrollees increased 2.6 percent per year from 1966 through 1986. Supplementary medical insurance (SMI) enrollment increased slightly faster than hospital insurance (HI) enrollment. Total enrollment jumped 10 percent from 1972 to 1973, reflecting the extension of Medicare coverage to the disabled by the 1972 Amendments to the Social Security Act. Prior to the 1972 amendments, only persons 65 years of age or over were covered by Medicare.

From fiscal year 1973 to fiscal year 1986, the number of Medicaid recipients (persons who received services paid for by Medicaid) increased 1.1 percent per year[1]. This upward trend included periods of growth and decline (Figure 2.1). In contrast, Medicare enrollment has grown steadily from 1966 to 1986.

Medicare enrollees

Table 2.2 contains data on the number of aged HI and SMI enrollees by age, sex, and race as of July 1 for the years 1966 through 1986. All demographic groups shown in the table grew in size, with SMI enrollment increasing at a greater rate than HI enrollment in each group. For both HI and SMI, enrollment increases were smaller for males than for females, for white persons than for persons of all other races, and for the younger age group (65-74 years) than for persons 75 years of age or over. The gradual aging of Medicare enrollees has long-term consequences for the Medicare program because older enrollees are higher users of health care services and increase the average reimbursement per Medicare enrollee.

Since 1973 when Medicare coverage was extended to disabled persons, the rate of growth in the number of disabled enrollees (Table 2.3) has been about double that of aged enrollees. For both HI and SMI, the greatest increase in enrollment among the disabled occurred in the age group 35-44 years. HI and SMI enrollment showed smaller increases for males than for females and for white enrollees than for all other races. HI and SMI enrollment of the disabled decreased from 1981 to 1984. Beneficiaries who receive social security disability benefits generally become eligible for Medicare 2 years after eligibility for the cash benefits. The decrease among the Medicare disabled reflects the decrease in the number of disabled persons awarded benefits under the disability insurance program during the period 1979 through 1982. Awards began to increase again in 1983. This is reflected in the Medicare enrollment figures for 1985 and 1986.

Medicaid recipients

Trend data on the number of Medicaid recipients by basis of eligibility and maintenance assistance status are presented in Table 2.4. Recipients are divided into two groups: those who receive cash payments as well as Medicaid benefits and those who receive medical assistance only. From fiscal year 1973 to fiscal year 1986, the total number of cash assistance recipients using Medicaid services increased at an average rate of 1.0 percent a year. The number of Medicaid recipients in the aged and blind cash assistance groups decreased during the same period at annual rates of 2.1 and 1.2 percent per year, respectively. Of all cash assistance groups, the highest rate of growth in the number of Medicaid recipients occurred among disabled enrollees. Most of this increase occurred from 1973 to 1977, when the total number of disabled cash recipients increased by more than one-half. The number of children under age 21, who comprise approximately one-half of all cash assistance Medicaid recipients, grew at an annual rate of 1.0 percent per year.

The number of Medicaid recipients receiving only medical assistance increased at a rate of 2.0 percent per year. Among recipients of medical assistance only, the number of disabled recipients and adults in low-income families with dependent children grew most rapidly, at rates of 4.7 and 8.5 percent per year, respectively. The number of blind recipients of medical assistance only decreased by an annual compound rate of 4.2 percent.

Data on Medicaid recipients in fiscal years 1973-86 are presented by age, sex, and race in Table 2.5. The number of recipients in the group 65 years of age or over decreased at an annual rate of 1.6 percent. The number in all other age groups grew at rates ranging from 0.7 to 4.0 percent per year. The number of female recipients grew at a slightly higher rate than males (1.2 and 0.9 percent respectively). White persons and those of all other races increased at about the same rate. Race was unknown for a significant number of recipients in some reporting States, so race data should be used with caution.

Expenditures

Data on Medicare benefit payments from the trust funds and Medicaid payments are shown in Table 2.6 and Figure 2.2. Total Medicare benefit payments grew at an average annual rate of 15.9 percent from 1967 to

[1] The Medicaid data presented in this report were first compiled in the present format in fiscal year 1973. Previous data were based on reporting categories different from those now used. To avoid erroneous inferences, the data for earlier years are excluded from this report.

Table 2.1

Number of Medicare enrollees by type of coverage and number of Medicaid recipients: 1966-86

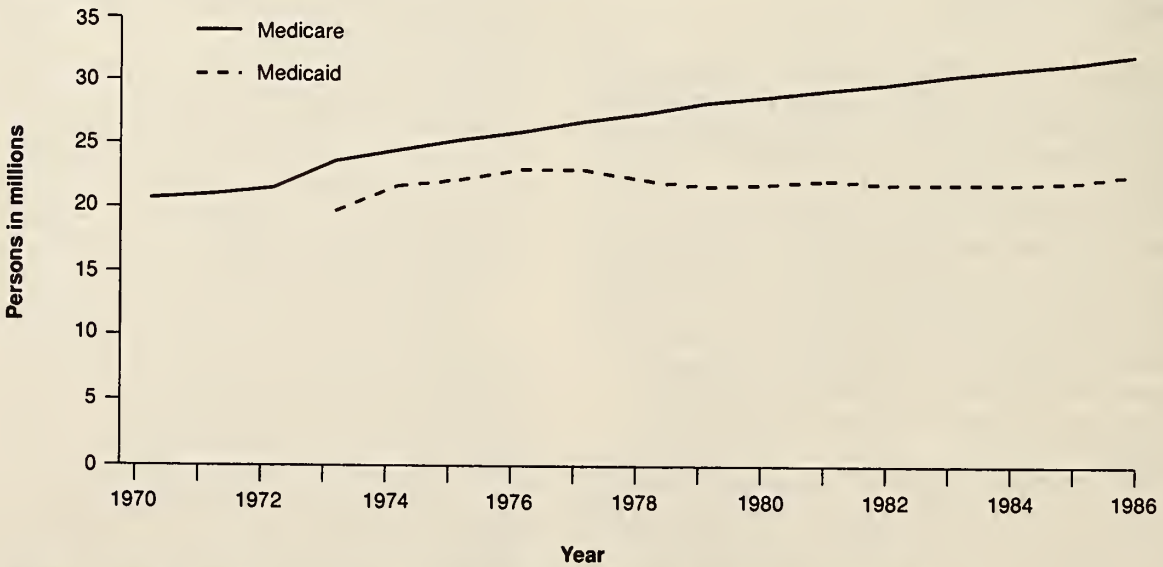
Year[1]	Medicare enrollees			Medicaid recipients
	Hospital insurance and/or supplementary medical insurance	Hospital insurance	Supplementary medical insurance	
	Number in thousands			
1966	19,108.8	19,082.5	17,736.0	—
1967	19,521.0	19,493.9	17,893.0	—
1968	19,821.0	19,769.7	18,804.8	—
1969	20,102.7	20,014.2	19,194.7	—
1970	20,490.9	20,361.2	19,584.4	—
1971	20,914 9	20,742.3	19,974.7	—
1972	21,332.1	21,115.3	20,351.3	—
1973	23,545.4	23,301.1	22,490.5	19,622.2
1974	24,201.0	23,924.1	23,166.6	21,462.2
1975	24,958.6	24,640.5	23,904.6	22,006.6
1976	25,662.9	25,312.6	24,614.4	22,814.6
1977	26,457.9	26,093.9	25,363.5	22,831.8
1978	27,164.2	26,777.3	26,074.1	21,964.8
1979	27,858.7	27,459.2	26,757.3	21,520.5
1980	28,478.2	28,066.9	27,399.7	21,604.6
1981	29,010.0	28,589.5	27,941.2	21,979.6
1982	29,494.2	29,069.0	28,412.3	21,603.2
1983	30,026.0	29,587.3	28,974.5	21,554.1
1984	30,455.4	29,996.0	29,415.4	21,607.0
1985	31,082.8	30,589.5	29,988.8	21,808.3
1986	31,749.7	31,215.5	30,589.7	22,517.7
			Percent	
ACRG[2]	2.6	2.5	2.8	1.1

[1] Medicare data are as of July 1 of each calendar year; Medicaid data are as of each fiscal year.
[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 2.1

Number of Medicare enrollees and Medicaid recipients: 1970-86



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.2

Number of aged Medicare enrollees, by type of coverage, age, sex, and race: July 1, 1966-86

Year	Hospital insurance							Supplementary medical insurance						
		Age		Sex		Race[1]			Age		Sex		Race[1]	
	Total	65-74 years	75 years or over	Male	Female	White	All other	Total	65-74 years	75 years or over	Male	Female	White	All other
	Number in thousands													
1966	19,082	11,990	7,092	8,133	10,950	17,042	1,445	17,736	11,186	6,550	7,534	10,202	15,938	1,264
1967	19,494	12,116	7,378	8,243	11,251	17,385	1,496	17,893	11,114	6,779	7,547	10,346	16,124	1,245
1968	19,770	12,158	7,611	8,318	11,452	17,632	1,525	18,805	11,561	7,244	7,878	10,927	16,877	1,368
1969	20,014	12,195	7,819	8,396	11,618	17,859	1,558	19,195	11,705	7,490	8,010	11,185	17,229	1,406
1970	20,361	12,316	8,045	8,507	11,855	18,187	1,608	19,584	11,873	7,711	8,132	11,452	17,576	1,472
1971	20,742	12,462	8,280	8,628	12,114	18,582	1,672	19,975	12,050	7,924	8,250	11,724	17,974	1,532
1972	21,115	12,641	8,474	8,744	12,371	18,930	1,693	20,351	12,248	8,104	8,360	11,991	18,325	1,557
1973	21,571	12,911	8,660	8,911	12,660	19,242	1,762	20,921	12,586	8,334	8,569	12,352	18,737	1,636
1974	21,996	13,182	8,814	9,005	12,991	19,601	1,809	21,422	12,925	8,496	8,694	12,727	19,149	1,704
1975	22,472	13,426	9,046	9,168	13,304	19,996	1,870	21,945	13,215	8,730	8,873	13,073	19,575	1,781
1976	22,920	13,691	9,229	9,324	13,596	20,382	1,916	22,446	13,529	8,917	9,047	13,399	19,995	1,845
1977	23,475	13,986	9,488	9,537	13,937	20,857	1,977	22,991	13,830	9,161	9,240	13,751	20,456	1,909
1978	23,984	14,259	9,725	9,728	14,256	21,289	2,036	23,531	14,119	9,412	9,436	14,094	20,906	1,978
1979	24,548	14,582	9,967	9,945	14,604	21,770	2,100	24,098	14,414	9,685	9,645	14,454	21,385	2,046
1980	25,104	14,892	10,210	10,156	14,948	22,244	2,160	24,680	14,726	9,954	9,868	14,813	21,876	2,114
1981	25,591	15,152	10,439	10,340	15,250	22,661	2,210	25,182	14,977	10,205	10,055	15,127	22,298	2,172
1982	26,115	15,386	10,728	10,538	15,577	23,104	2,265	25,707	15,192	10.515	10,250	15,457	22,738	2,231
1983	26,670	15,631	11,040	10,755	15,915	23,575	2,322	26,292	15,450	10,843	10,479	15,813	23,231	2,296
1984	27,112	15,805	11,306	10,920	16,192	23,945	2,374	26,764	15,633	11,131	10,652	16,112	23,619	2,358
1985	27,683	16,111	11,572	11,146	16,536	24,424	2,444	27,311	15,884	11,426	10,852	16,459	24,060	2,441
1986	28,257	16,424	11,833	11,378	16,879	24,902	2,515	27,863	16,148	11,715	11,058	16,805	24,498	2,528
	Percent													
ACRG[2]	2.0	1.6	2.6	1.7	2.2	1.9	2.8	2.3	1.9	2.9	1.9	2.5	2.2	3.5

[1] Excludes unknown race.

[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.3
Number of disabled Medicare enrollees, by age, sex, race, and type of coverage: July 1, 1973-86

Type of coverage and year	Total	Age				Sex		Race[1]	
		Under 35 years	35-44 years	45-54 years	55-64 years	Male	Female	White	All other
Hospital insurance				Number in thousands					
1973	1,730.5	192.4	218.0	438.8	881.4	1,118.8	611.8	1,444.9	253.2
1974	1,928.1	220.2	237.6	481.4	988.9	1,232.1	696.0	1,602.3	287.1
1975	2,168.4	254.3	261.7	530.0	1,122.4	1,380.9	787.5	1,800.9	329.2
1976	2,392.2	288.3	285.8	574.0	1,244.1	1,514.3	877.8	1,983.2	370.9
1977	2,619.4	322.6	310.6	617.3	1,368.9	1,654.2	965.2	2,163.0	415.1
1978	2,793.2	344.8	335.4	646.5	1.466.5	1,763.0	1,030.2	2,299.1	447.8
1979	2,910.8	361.4	356.0	658.0	1,535.3	1,837.4	1,073.4	2,388.1	471.4
1980	2,963.2	371.2	369.5	657.5	1,565.0	1,870.5	1,092.6	2,422.2	486.7
1981	2,999.0	383.5	385.1	654.7	1,575.6	1,896.0	1,102.9	2,442.1	499.9
1982	2,954.2	377.7	386.0	622.2	1,568.4	1,865.2	1,089.0	2,399.6	497.3
1983	2,917.6	379.7	400.1	598.1	1,539.7	1,845.6	1,071.9	2,362.0	498.7
1984	2,884.4	388.2	422.2	584.2	1,489.7	1,830.2	1,054.2	2,325.9	502.2
1985	2,906.9	400.3	442.8	593.1	1,470.7	1,846.4	1,060.5	2,336.3	513.0
1986	2,958.5	432.9	497.6	613.0	1,415.0	1,880.6	1,077.9	2,355.1	547.8
				Percent					
ACRG[2]	4.2	6.4	6.6	2.6	3.7	4.1	4.5	3.8	6.1
Supplementary medical insurance				Number in thousands					
1973	1,569.9	174.9	194.7	390.2	810.0	1,003.3	566.6	1,307.7	233.4
1974	1,745.0	194.0	211.0	428.0	912.0	1,102.0	643.0	1,446.0	263.1
1975	1,959.2	225.8	232.3	469.2	1,032.0	1,230.6	728.7	1,622.3	300.3
1976	2,168.5	258.3	255.7	510.2	1,144.3	1,352.8	815.7	1,792.6	339.6
1977	2,372.6	290.0	278.8	548.7	1,255.2	1,475.4	897.3	1,954.3	379.3
1978	2,543.2	311.9	303.1	579.2	1,349.0	1,581.8	961.3	2,088.9	411.0
1979	2,658.8	328.6	323.4	592.6	1,414.3	1,655.1	1,003.7	2,176.7	433.9
1980	2,719.2	339.7	337.1	596.3	1,446.1	1,694.6	1,024.7	2,218.2	449.8
1981	2,759.5	352.7	352.3	596.3	1,458.2	1,723.9	1,035.6	2,242.3	463.5
1982	2,705.5	345.8	347.4	561.1	1,451.2	1,687.6	1,017.9	2,192.7	458.7
1983	2,682.4	349.5	362.9	542.7	1,427.4	1,677.4	1,005.0	2,167.3	461.3
1984	2,651.2	358.0	382.3	530.0	1,380.9	1,663.9	987.4	2,134.3	463.8
1985	2,677.9	370.3	402.4	540.3	1,364.9	1,683.2	994.7	2,147.8	475.8
1986	2,727.0	400.5	452.8	561.1	1,312.6	1,717.4	1,009.6	2,166.7	508.2
				Percent					
ACRG[2]	4.3	6.6	6.7	2.8	3.8	4.2	4.5	4.0	6.2

[1] Excludes unknown race.
[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.4
Number of Medicaid recipients, by maintenance assistance status and basis of eligibility: Fiscal years 1973-86

Year	Cash assistance						Medical assistance only						
					Families with dependent children						Families with dependent children		
	Total[1]	Aged	Blind	Disabled	Children under 21 years[2]	Adults	Total[1]	Aged	Blind	Disabled	Children under 21 years	Adults	Other title XIX[2]
	Number in thousands												
1973	14,519.9	2,226.9	83.6	1,425.4	7,167.3	3,616.7	5,102.3	1,268.6	17.7	378.7	1,641.4	449.7	1,346.2
1974	15,969.1	2,510.3	99.9	1,810.8	7,820.2	3,727.8	5,147.3	1,191.4	29.2	386.8	1,652.2	562.9	1,324.9
1975	16,678.0	2,416.2	84.6	1,865.8	8,349.3	3,962.1	5,328.6	1,199.1	24.7	489.1	1,248.9	567.0	1,799.9
1976	17,221.9	2,396.7	78.5	2,037.7	8,527.0	4,182.0	5,592.7	1,215.5	18.4	534.5	1,396.6	591.3	1,836.4
1977	17,066.9	2,367.7	76.0	2,172.0	8,359.7	4,091.6	5,764.9	1,267.9	16.3	537.9	1,291.1	693.3	1,958.5
1978	16,423.0	2,133.4	67.2	2,081.9	8,165.3	3,975.2	5,541.8	1,242.4	14.6	554.0	1,210.3	668.0	1,852.5
1979	16,055.9	2,092.5	67.5	2,088.6	7,905.9	3,901.4	5,464.6	1,271.8	11.7	585.1	1,200.5	668.2	1,727.3
1980	16,497.2	2,035.3	76.7	2,186.4	8,114.2	4,093.5	5,390.9	1,404.8	14.9	632.5	1,219.0	783.2	1,499.1
1981	16,871.8	1,952.6	71.1	2,254.9	8,305.9	4,327.5	5,492.9	1,414.0	15.3	737.8	1,274.8	859.7	1,364.3
1982	16,594.1	1,850.7	72.7	2,190.6	8,187.0	4,370.1	5,642.5	1,389.0	11.6	615.7	1,376.5	986.2	1,433.7
1983	16,519.4	1,815.7	66.4	2,201.9	8,079.3	4,494.4	5,855.3	1,556.0	10.6	642.5	1,456.0	1,098.1	1,128.6
1984	16,478.1	1,729.8	69.1	2,197.5	8,156.8	4,429.6	5,990.6	1,508.4	10.0	636.3	1,527.10	1,170.1	1,186.7
1985	16,458.7	1,663.2	70.9	2,294.7	8,155.3	4,329.1	6,023.5	1,398.2	9.5	641.7	1,597.0	1,188.4	1,213.6
1986	16,595.9	1,679.8	71.4	2,413.7	8,188.4	4,345.0	6,639.5	1,460.1	10.1	686.0	1,842.3	1,301.6	1,365.9
	Percent												
ACRG[3]	1.0	-2.1	-1.2	4.1	1.0	1.4	2.0	1.1	-4.2	4.7	0.9	8.5	0.1

[1] Totals for each year include estimated recipient counts for nonreporting States. The sum of recipients in the maintenance assistance categories exceeds total recipients because recipients who are eligible in more than one category are counted in each category but only once in the total.
[2] Cash assistance to other title XIX recipients was phased out after 1974; title XIX cash assistance data for 1973-74 are included with data for children under 21 years.
[3] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.5
Number of Medicaid recipients, by age, sex, and race: Fiscal years 1973-86

Year	Total	Age				Sex		Race		
		Under 6 years	6-20 years	21-64 years	65 years or over	Male	Female	White	All other	Unknown
	Number in thousands									
1973	19,622.2	2,890.4	5,943.6	6,292.8	4,495.4	7,222.9	12,399.3	—	—	—
1974	21,462.2	3,466.1	6,827.0	7,423.7	3,745.1	7,462.4	13,999.6	—	—	—
1975	22,006.6	3,334.0	7,257.7	7,660.5	3,754.3	7,686.9	14,319.7	8,234.6	6,105.9	7,666.0
1976	22,814.6	3,584.2	7,706.7	7,843.7	3,680.0	7,973.7	14,840.9	8,355.4	6,598.2	7,861.0
1977	22,831.8	3,490.9	7,331.3	8,235.4	3,774.1	8,034.5	14,797.3	8,439.1	6,396.5	7,996.2
1978	21,964.8	3,402.4	7,165.0	7,874.3	3,523.1	7,639.3	14,325.5	8,121.5	6,247.0	7,596.3
1979	21,520.5	3,398.1	6,850.0	7,504.2	3,768.3	7,467.6	14,052.9	8,036.2	7,119.4	6,364.8
1980	21,604.6	4,017.5	6,906.4	7,350.1	3,330.5	7,702.4	13,902.2	7,846.7	6,275.9	7,481.8
1981	21,979.6	4,087.2	7,026.3	7,477.7	3,388.3	7,836.1	14,143.5	7,982.9	6,384.8	7,611.7
1982	21,603.2	3,996.6	6,848.2	6,999.4	3,759.0	7,777.2	13,826.0	8,142.7	6,209.5	7,251.0
1983	21,554.1	3,660.1	6,576.1	7,352.3	3,965.6	7,811.8	13,742.3	9,294.9	8,390.8	3,868.3
1984	21,607.0	4,476.1	6,293.5	7,214.0	3,623.5	7,943.5	13,663.6	9,520.3	9,061.5	3,025.3
1985	21,808.3	4,680.9	6,339.5	7,265.2	3,522.7	7,850.3	13,958.0	11,419.2	8,638.5	1,750.5
1986	22,517.7	4,837.6	6,507.8	7,538.2	3,634.0	8,117.4	14,400.2	11,892.4	8,724.4	1,900.9
	Percent									
ACRG[1]	1.1	4.0	0.7	1.4	-1.6	0.9	1.2	3.4	3.3	-11.9

[1] Annual compound rate of growth.

NOTE: A small number of persons of unknown age or sex have been distributed among age and sex categories. However, the number of persons of unknown race is too great to be accurately estimated. Consequently, data by race should be used with caution.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office and Data Management.

Table 2.6

Medicare benefit payments by type of coverage, Medicaid payments by basis of eligibility, and percent change in total from previous year: 1966-86

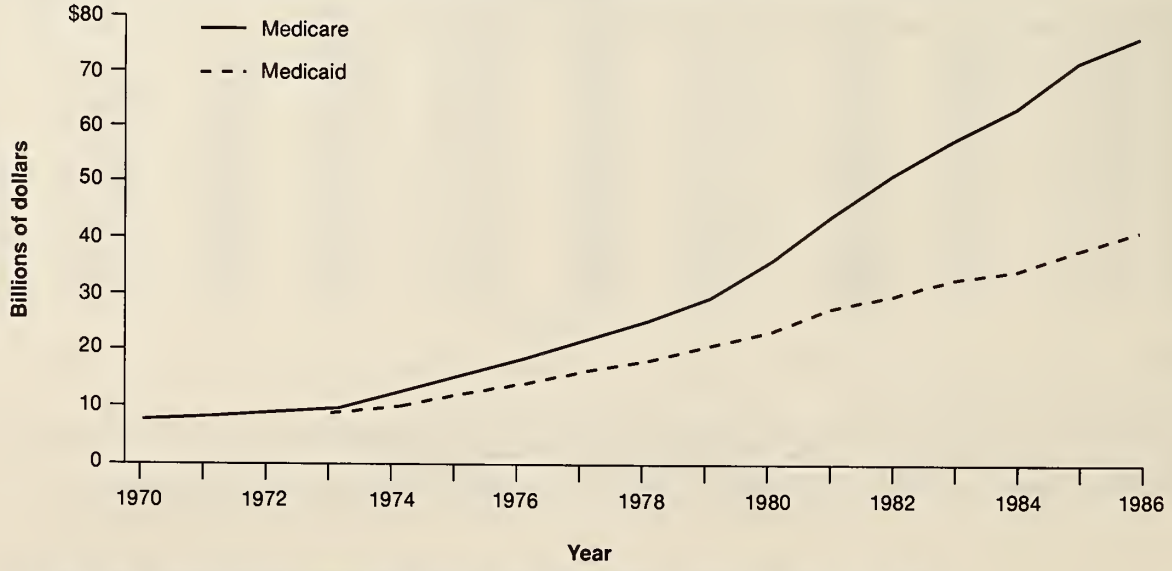
Year[1]	Medicare benefit payments				Medicaid payments				
		Coverage			Basis of eligibility				
	Total	Hospital insurance	Supplementary medical insurance	Percent change	Total	Families with dependent children	Aged, blind, and disabled	Other	Percent change
	Amounts in millions				Amounts in millions				
1966[2]	$1,019	$891	$128	NA	—	—	—	—	—
1967	4,549	3,353	1,197	346.4	—	—	—	—	—
1968	5,697	4,179	1,518	25.2	—	—	—	—	—
1969	6,603	4,739	1,865	15.9	—	—	—	—	—
1970	7,099	5,124	1,975	7.5	—	—	—	—	—
1971	7,868	5,751	2,117	10.8	—	—	—	—	—
1972	8,643	6,318	2,325	9.9	—	—	—	—	—
1973[3]	9,583	7,057	2,526	10.9	$8,640	$2,872	$5,315	$452	NA
1974	12,418	9,099	3,318	29.6	9,983	3,398	6,159	425	15.5
1975	15,588	11,315	4,273	25.5	12,242	4,248	7,503	492	22.6
1976	18,420	13,340	5,080	18.2	14,091	4,719	8,830	542	15.1
1977	21,774	15,737	6,038	18.2	16,239	5,216	10,382	641	15.2
1978	24,934	17,682	7,252	14.5	17,992	5,421	11,929	643	10.8
1979	29,331	20,623	8,708	17.6	20,472	5,905	13,928	638	13.8
1980	35,699	25,064	10,635	21.7	23,311	6,354	16,361	596	13.9
1981	43,455	30,342	13,113	21.7	27,204	7,271	19,381	552	16.7
1982	51,086	35,631	15,455	17.6	29,399	7,567	21,144	689	8.1
1983	57,443	39,377	18,106	12.4	32,391	8,322	23,321	747	10.2
1984	62,918	43,257	19,661	9.5	33,891	8,398	24,793	700	4.6
1985	70,527	47,580	22,947	12.1	37,508	9,161	27,549	798	10.7
1986	75,997	49,758	26,239	7.8	41,027	10,013	30,024	991	9.4
				Percent					
ACRG[4]	16.0	15.3	17.6	NA	12.7	10.1	14.2	6.2	NA

[1] Medicare data are for calendar years; Medicaid data are for fiscal years.
[2] July-December only.
[3] Disabled enrollees were covered by Medicare on July 1, 1973.
[4] Annual compound rate of growth. ACRG computed for 1967-86 for Medicare and 1973-86 for Medicaid.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare Cost Estimates.

Figure 2.2

Medicare benefit payments and Medicaid payments: 1970-86



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Medicare Cost Estimates and the Office of Statistics and Data Management.

1986. SMI benefit payments increased more rapidly than HI benefit payments. The large increase in total benefit payments from 1973 to 1974, 29.6 percent, reflects the extension of Medicare coverage to the disabled. The extension of coverage to the disabled also accelerated the rate of increase in SMI benefit payments, largely because of the rising number of end stage renal disease (ESRD) patients for whom dialysis services are covered under SMI.

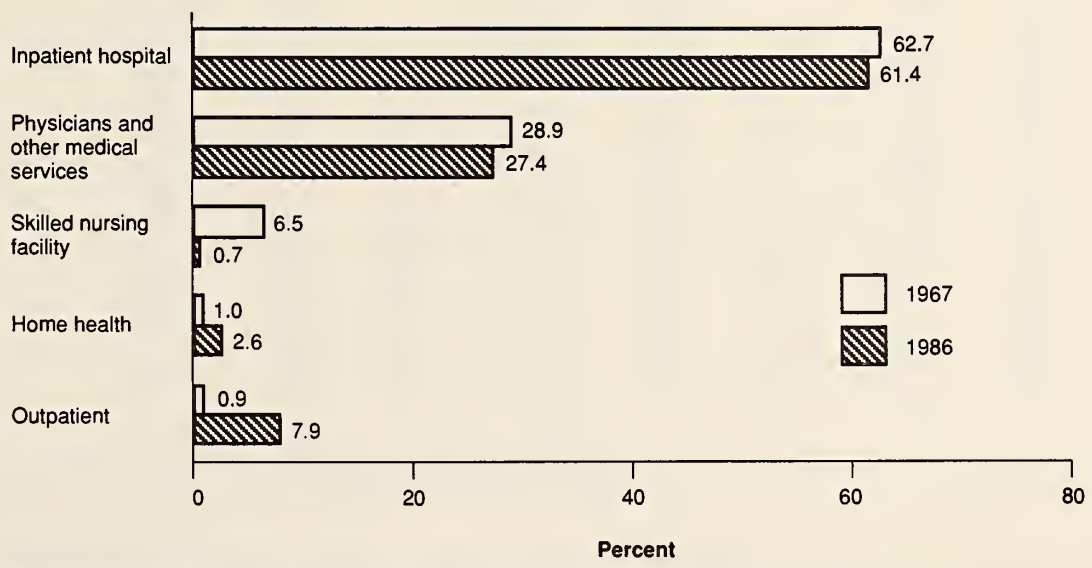
Medicaid payments also increased, growing at an average annual rate of 12.7 percent from fiscal year 1973 to fiscal year 1986. Payments for the aged and disabled grew the fastest at an average annual rate of 14.2 percent (Table 2.6). As indicated in Figure 2.2, the rate of increase in Medicare reimbursement historically has been higher than that for Medicaid payments.

Changes over time in the distribution of Medicare reimbursements and Medicaid payments by type of service covered are shown in Figures 2.3 and 2.4. The proportion of Medicare reimbursements for inpatient hospital services decreased slightly, from 62.7 percent in 1967 to 61.4 percent in 1986. During the same period, a small decrease (from 28.9 percent in 1967 to 27.4 percent in 1986) occurred in the proportion of all Medicare reimbursements made for physicians' and other medical services. The proportion of total Medicaid payments for inpatient hospital (general and mental hospital) services decreased from 34.8 percent in 1973 to 28.0 percent in 1986. As in the case of Medicare, physician payments as a proportion of total Medicaid payments also decreased, from 10.7 percent in 1973 to 6.2 percent in 1986.

From 1967 to 1986, reimbursements for outpatient services as a proportion of all Medicare reimbursements increased more than eightfold, from 0.9 percent to 7.9 percent. In part, this increase reflects use of renal dialyses by ESRD patients (Figure 2.3). Medicaid payments for outpatient services increased at a much slower rate, from 3.1 percent in 1973 to 4.8 percent in 1986 (Figure 2.4). The share of Medicare reimbursements for home health agency services increased from 1.0 percent in 1967 to 2.6 percent in 1986. The proportion of Medicare reimbursements for skilled nursing facility (SNF) services decreased markedly from 1967 (6.5 percent) to 1986 (0.7 percent). The reason for this decrease is discussed in more detail in the section on SNF services. In contrast, Medicaid payments for SNF services and intermediate care facility (ICF) services increased from 34.9 percent in 1973 to 42.8 percent in 1986. As shown in these figures, long-term care services account for the largest proportion of total Medicaid payments; in contrast, Medicare is more of an acute care program.

Figure 2.3

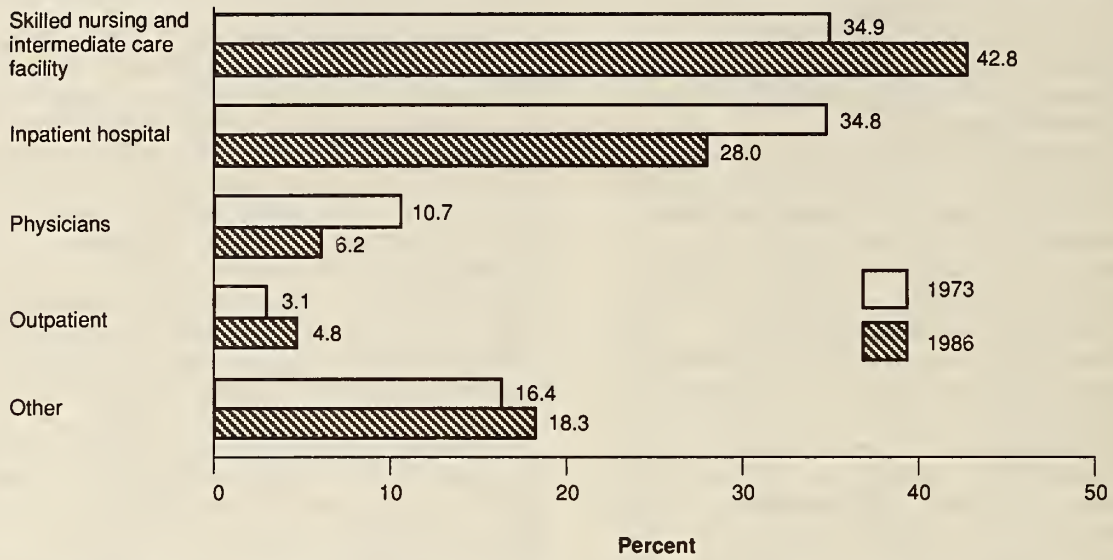
Percent distribution of Medicare reimbursements, by type of service: Calendar years 1967 and 1986



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 2.4

Percent distribution of Medicaid payments, by type of service: Fiscal years 1973 and 1986



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Medicare reimbursements

Trend data on Medicare reimbursements based on claims paid in a calendar year are shown in Table 2.7 by type of coverage and type of enrollee. Successive increases in reimbursements for each entitlement group resulted in an average annual increase of 15.3 percent in total reimbursements from 1968 to 1986. Some of this increase reflects, of course, the extension of Medicare coverage to disabled persons in 1973. As derived from Table 2.7, reimbursements for the disabled grew much faster than reimbursements for the aged, increasing to 11.7 percent of total reimbursements in 1986 from 8.7 percent in 1974.

As shown in Figure 2.5, a small proportion of enrollees with large medical expenses accounted for a large proportion of Medicare reimbursements for both aged and disabled enrollees. Enrollees reimbursed $15,000 or more represented only 3.1 percent of all aged persons ever enrolled in 1986 but accounted for 38.0 percent of all Medicare reimbursements for the aged. At the other extreme, 30.7 percent of aged enrollees received no reimbursement during the year. (Persons having no reimbursement are those not having covered Medicare charges, not exceeding Medicare deductibles, exceeding deductibles but not filing claims, or receiving covered services without charge.) Another 43.3 percent of aged enrollees received less than $1,000 in reimbursements and accounted for only 5.5 percent of all Medicare reimbursements for the aged.

An even more graphic example of how health insurance spreads the risk of illness is provided by comparable figures for the disabled. Although representing only 4.8 percent of all disabled enrollees, those in the group reimbursed $15,000 or more accounted for 54.7 percent of all Medicare reimbursements for disabled enrollees. High-cost users account for a larger share of reimbursements in the disabled group than in the aged group, partly because of the significantly greater proportion of ESRD patients among disabled enrollees. The major portion of reimbursements for persons with ESRD is for renal dialysis services which, on average, need to be carried out three times weekly at about $100 per session. Another 38.0 percent of the disabled received no reimbursement.

Table 2.7

Medicare reimbursements, by type of coverage and type of enrollee: Calendar years 1966-86

Year	Hospital insurance and supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Total	Aged [1]	Disabled [2]	Total	Aged [1]	Disabled [2]	Total	Aged [1]	Disabled [2]
	Amount in millions								
1966-67 [3]	$5,145.2	$5,145.2	NA	$3,839.9	$3,839.9	NA	$1,305.3	$1,305.3	NA
1968	5,289.5	5,289.5	NA	3,766.9	3,766.9	NA	1,522.6	1,522.6	NA
1969	6,267.6	6,267.6	NA	4,597.4	4,597.4	NA	1,670.3	1,670.3	NA
1970	6,572.0	6,572.0	NA	4,740.3	4,740.3	NA	1,831.6	1,831.6	NA
1971	7,354.4	7,354.4	NA	5,358.2	5,358.2	NA	1,996.2	1,996.2	NA
1972	8,019.4	8,019.4	NA	5,835.7	5,835.7	NA	2,183.7	2,183.7	NA
1973	9,251.2	9,038.7	[4]$212.6	6,847.9	6,674.3	[4]$173.6	2,403.3	2,364.3	[4]$39.0
1974	11,238.0	10,257.5	980.5	8,118.4	7,454.4	664.0	3,119.6	2,803.1	316.5
1875	14,548.5	13,056.1	1,492.4	10,519.1	9,537.4	981.8	4,029.4	3,518.7	510.6
1976	17,619.0	15,636.5	1,982.5	12,793.9	11,495.8	1,298.1	4,825.1	4,140.7	684.4
1977	20,476.8	18,014.7	2,462.1	14,709.9	13,116.3	1,593.6	5,766.9	4,898.4	868.5
1978	23,542.7	20,579.1	2,963.6	16,630.3	14,740.7	1,889.7	6,912.4	5,838.4	1,073.9
1979	27,699.1	24,005.0	3,694.1	19,257.9	16,940.4	2,317.4	8,441.2	7,064.5	1,376.7
1980	33,724.7	29,224.2	4,500.5	23,194.2	20,404.1	2,790.1	10,530.5	8,820.1	1,710.4
1981	39,918.4	36,614.0	5,304.4	27,486.4	24,180.5	3,305.9	12,432.0	10,433.5	1,998.5
1982	48,134.3	41,786.8	6,347.4	33,332.8	29,360.3	3,972.5	14,801.5	12,426.5	2,374.9
1983	53,437.9	46,726.8	6,711.1	36,313.6	32,140.6	4,173.0	17,124.4	14,586.2	2,538.2
1984 [5]	59,132.2	52,118.1	7,014.1	40,607.5	36,083.8	4,523.7	18,524.7	16,034.3	2,490.4
1985 [5]	63,876.5	56,427.9	7,448.6	42,265.9	37,510.7	4,755.3	21,611.2	18,917.9	2,693.3
1986 [5]	68,862.9	60,809.9	8,053.0	44,565.7	39,506.5	5,059.2	24,297.3	21,303.5	2,993.8
				Percent					
ACRG [6]	15.3	14.5	19.2	14.7	13.9	18.4	16.6	15.8	20.6

[1] For all enrollees 65 years of age or over, including those with end stage renal disease.

[2] For all enrollees under 65 years of age, including those with end stage renal disease. Disabled enrollees were not covered under Medicare until July 1, 1973.

[3] July 1966 through December 1967.

[4] Represents reimbursements for the last 6 months of 1973, recorded on a claims approved basis.

[5] Starting in 1984, hospital insurance reimbursement amounts are based on expenditures reported on Health Care Financing Administration (HCFA) billing form HCFA-1450 plus prospective payment system short-stay hospital inpatient passthrough expenditures as reported on HCFA intermediary benefit payment report.

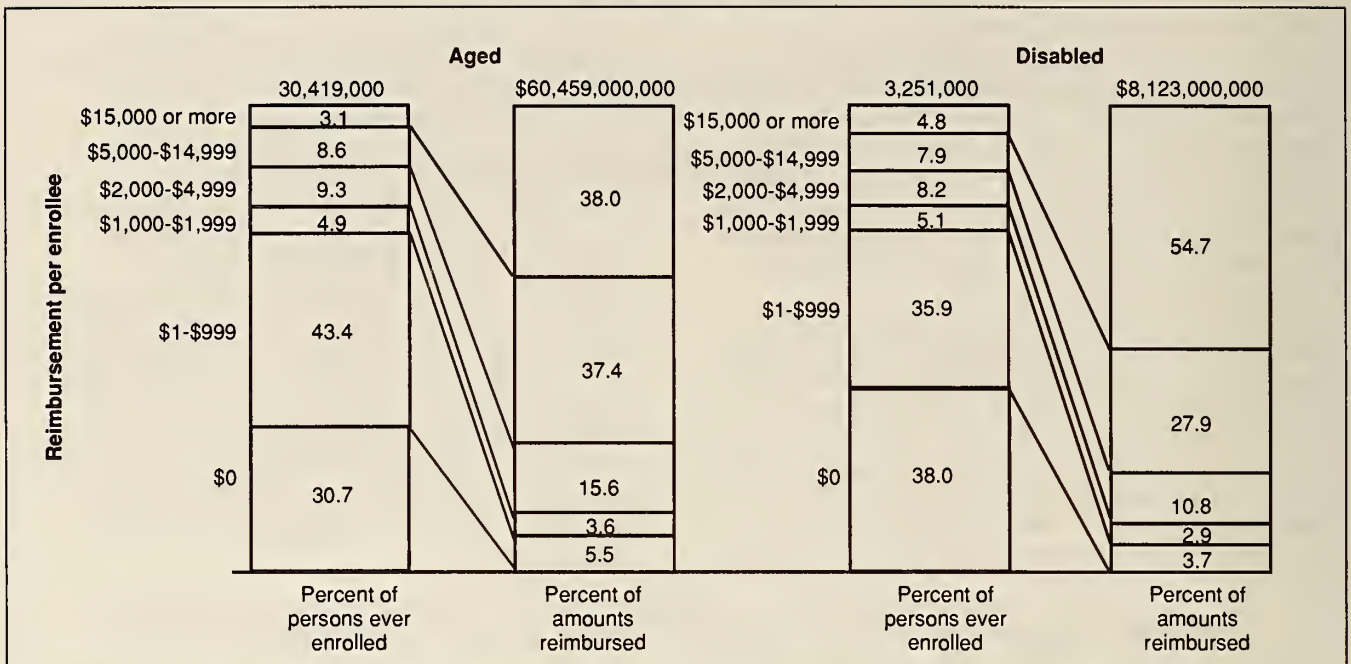
[6] Annual compound rate of growth. ACRG computed for 1968-86 the aged and 1974-86 for the disabled.

NOTE: Reimbursements, except those for the disabled in 1973, are amounts paid in a calendar year. Reimbursements are not adjusted for claims paid after data were compiled. Reimbursement data differ from data benefits payments shown in Table 2.6, which include both interim reimbursements and retroactive adjustments made to institutional providers.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 2.5

Percent distribution of aged and disabled Medicare enrollees and reimbursements per enrollee: Calendar year 1986



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Medicaid payments

As shown in Table 2.8, Medicaid payments have been growing fastest for the disabled in both maintenance assistance groups. From 1973 to 1986, payments for the disabled who received only medical assistance increased at an average rate of 17.8 percent (to $5.7 billion in 1986), and payments for the disabled who received cash assistance increased at a rate of 15.7 percent (to $8.9 billion in 1986). The slowest rates of increase occurred for other title XIX recipients and for children under 21 years of age not receiving cash assistance, with average rates of growth of 6.2 and 7.4 percent, respectively.

Trends in Medicaid payments for long-term care, inpatient hospital services, and all other Medicaid services are shown in Figure 2.6. Payments for long-term care services increased steadily from fiscal year 1973 to fiscal year 1986. Inpatient hospital services and the remaining Medicaid services also increased, but the increases were not as great.

Medicaid expenditures by age, sex, and race of recipients are reported in Table 2.9. As with Table 2.5, some States did not report recipients' race. From 1973 to 1986, variations in the growth of expenditures by age ranged from an annual average of 12.1 percent for persons 6-20 years of age to 15.0 percent for children under 6. Increases in payments on behalf of male recipients were similar to those for female recipients (13.0 and 12.6 percent, respectively).

As with Medicare, a small number of recipients consume a disproportionate share of Medicaid payments. The share of total recipients and total payments accounted for by each of five eligibility groups is shown in Figure 2.7. In fiscal year 1986, the low-income aged accounted for 13.9 percent of all recipients and 36.8 percent of all payments. Similarly, the low-income blind and disabled accounted for only 14.1 percent of all recipients but 36.4 percent of all payments. Together, the aged, blind, and disabled accounted for 28.0 percent of all recipients and 73.2 percent of all payments. At the opposite end of the spectrum are children in low-income families, who accounted for 44.5 percent of all recipients but only 12.5 percent of all payments.

Table 2.8

Medicaid payments, by maintenance assistance status and basis of eligibility: Fiscal years 1973-86

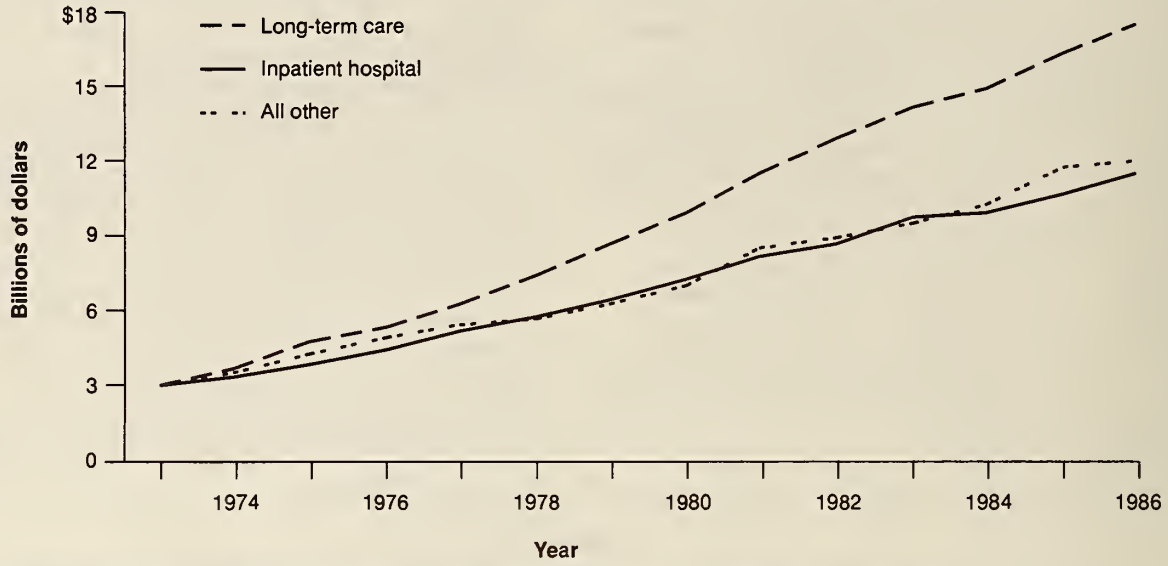
	Cash assistance						Medical assistance only						
					Families with dependent children						Families with dependent children		
Year	Total[1]	Aged	Blind	Disabled	Children under 21 years[2]	Adults	Total[1]	Aged	Blind	Disabled	Children under 21 years	Adults	Other title XIX[2]
	Amount in millions												
1973	$4,693.5	$985.0	$46.4	$1,335.6	$1,048.7	$1,277.8	$3,947.4	$2,250.5	$18.5	$680.5	$377.6	$168.3	$452.0
1974	5,603.9	1,177.5	54.5	1,605.2	1,319.4	1,447.3	4,378.8	2,513.7	25.3	783.1	374.6	257.1	425.0
1975	7,188.3	1,340.9	60.7	2,041.6	1,850.5	1,894.7	5,054.0	3,016.9	32.2	1,010.6	335.6	167.0	491.6
1976	8,154.4	1,448.2	60.4	2,486.3	2,076.1	2,083.3	5,936.3	3,461.8	35.5	1,337.6	354.5	204.9	541.9
1977[3]	9,576.6	1,707.6	75.4	3,189.5	2,246.0	2,358.1	6,662.3	3,791.0	40.7	1,577.8	364.3	247.9	640.7
1978[3]	10,160.0	1,799.0	74.4	3,431.5	2,439.5	2,415.5	7,832.5	4,509.4	41.2	2,073.2	308.9	257.2	642.6
1979	11,281.3	1,879.4	76.0	4,020.2	2,567.1	2,738.6	9,190.4	5,166.6	32.4	2,753.8	317.3	282.2	638.2
1980	12,344.1	2,196.4	87.6	4,479.1	2,698.4	2,882.6	10,966.7	6,542.8	36.8	3,017.8	424.3	348.9	596.2
1981	14,534.2	2,480.2	108.5	5,615.7	3,002.2	3,327.6	12,670.1	7,445.9	45.5	3,685.1	506.1	435.0	552.5
1982	15,861.6	2,705.3	120.5	6,468.0	2,978.5	3,589.3	13,537.8	8,033.8	51.9	3,764.7	495.0	503.8	688.5
1983	17,112.1	3,003.9	132.7	6,866.1	3,256.0	3,853.2	15,278.9	8,950.0	50.5	4,318.1	579.6	633.3	747.4
1984	17,564.1	3,192.4	151.1	7,092.1	3,377.2	3,751.3	16,326.9	9,623.0	67.8	4,666.3	601.3	668.5	700.0
1985	19,316.2	3,510.0	173.2	8,036.5	3,639.8	3,956.8	18,191.4	10,586.3	76.2	5,166.3	774.5	789.6	798.4
1986	21,039.1	3,784.9	188.1	8,905.3	4,180.2	3,980.5	19,988.1	11,314.9	89.4	5,741.5	955.5	896.3	990.7
	Percent												
ACRG[4]	12.2	10.9	11.4	15.7	11.2	9.1	13.3	13.2	12.9	17.8	7.4	13.7	6.2

[1] Totals for each year include estimated payments for nonreporting States. Payments by basis of eligibility may not sum to total because of rounding.
[2] Cash assistance to other title XIX recipients was phased out after 1974; title XIX cash assistance data for 1973-74 are included with data for other title XIX, medical assistance only.
[3] Data for 1977 and 1978 have been adjusted to distribute small amounts of payments on behalf of persons whose basis of eligibility was unknown.
[4] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 2.6

Medicaid payments for long-term care, inpatient hospital, and all other services: Fiscal years 1973-86



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.9

Medicaid payments, by age, sex, and race of recipient: Fiscal years 1973-86

Year	Total	Age				Sex		Race		
		Under 6 years	6-20 years	21-64 years	65 years or over	Male	Female	White	All other	Unknown
					Amounts in millions					
1973	$8,640	$537.4	$1,067.9	$3,696.2	$3,338.5	$2,886.6	$5,753.4	—	—	—
1974	9,983	601.0	1,335.7	4,140.0	3,906.3	3,235.5	6,747.5	—	—	—
1975	12,242	717.4	1,712.7	5,021.7	4,790.3	3,908.8	8,333.2	$5,920.0	$2,635.5	$3,686.4
1976	14,091	880.7	2,046.0	5,837.8	5,326.4	4,535.9	9,555.1	6,645.5	3,122.0	4,323.5
1977	16,239	1,000.4	2,459.2	6,865.8	5,912.7	5,274.5	10,964.5	8,134.4	3,546.1	4,558.6
1978	17,992	1,149.7	2,526.1	7,544.0	6,772.2	5,919.4	12,072.6	9,053.0	4,038.2	4,900.8
1979	20,472	1,244.5	2,712.3	8,522.0	7,993.6	6,677.9	13,794.1	11,052.0	5,271.5	4,148.5
1980	23,311	1,736.0	3,285.0	9,872.6	8,417.3	7,802.2	15,508.9	12,360.1	4,896.4	6,054.5
1981	27,204	2,040.3	3,318.9	11,099.2	10,745.5	9,113.3	18,090.7	18,634.7	6,257.0	2,312.3
1982	29,399	2,505.0	3,586.6	11,994.7	11,612.6	9,848.7	19,550.3	20,138.3	6,761.8	2,498.9
1983	32,391	1,904.6	4,062.1	13,265.7	13,158.5	11,001.9	21,389.1	19,618.8	7,408.9	5,363.3
1984	33,891	2,485.8	4,043.1	13,739.6	13,622.4	11,713.6	22,177.4	22,545.8	7,971.3	3,373.9
1985	37,508	2,875.5	4,410.8	15,059.6	15,161.7	12,868.1	24,639.5	26,796.5	10,217.6	493.6
1986	41,027	3,322.4	4,708.0	16,857.0	16,140.0	14,140.2	26,887.1	29,542.2	11,029.7	455.4
					Percent					
ACRG[1]	12.7	15.0	12.1	12.4	12.9	13.0	12.6	15.7	13.9	-17.3

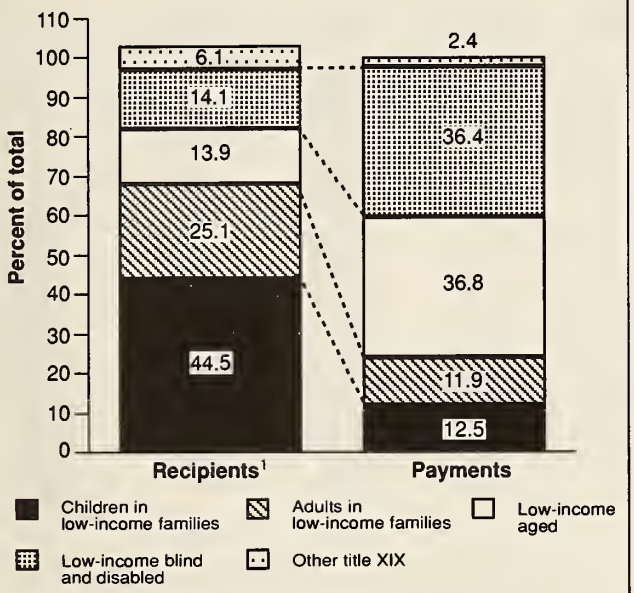
[1] Annual compound rate of growth.

NOTE: A small number of persons of unknown age or sex have been distributed among age and sex categories. However, the number of persons of unknown race is too great to be accurately estimated. Consequently, data by race should be used with caution.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 2.7

Percent distribution of Medicaid recipients and payments, by basis of eligibility: Fiscal year 1986



[1]The sum of percentages by basis of eligibility exceeds 100 percent because a recipient may be counted in more than one eligibility group.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Short-stay hospital and physicians' services

Data on Medicare and Medicaid short-stay inpatient hospital use are presented in Table 2.10. Discharges, covered days of care, reimbursements for Medicare enrollees, and payments for Medicaid recipients are included. Disabled Medicare enrollees exhibited the highest rates of growth in discharges, days of care, and reimbursements. This reflects the rapid rate of increase in enrollment by disabled persons in the 1970s (Table 2.3). Number of discharges and days of care decreased from 1983 to 1986 for both Medicare aged and disabled patients. For short-stay hospital services, growth rates of Medicare reimbursements for the aged (14.6 percent) and the disabled (18.4 percent) were higher than those of Medicaid payments (11.0 percent).

Data on Medicare reimbursements and Medicaid payments for physicians' services are reported in Table 2.11. As for inpatient hospital services, reimbursements for physicians' services grew the fastest for disabled Medicare enrollees, 20.1 percent a year from 1974 to 1986. Medicaid payments for physicians' services grew the slowest, 8.1 percent a year from 1973 to 1986.

These trends in Medicare reimbursements and Medicaid payments for short-stay hospital and physicians' services are displayed in Figures 2.8 and 2.9. As shown in each figure, Medicaid payments have been growing more slowly than Medicare reimbursements in recent years.

Selected other services

Medicare services

Medicare reimbursement trends for skilled nursing care, outpatient sevices, and home health services are shown in Figure 2.10. The trend line for outpatient care graphically illustrates the sharp increase in reimbursements that occured after the entry of disabled and ESRD enrollees in 1973. More detailed information on these trends is presented in Tables 2.12, 2.13, and 2.14.

Skilled nursing facility services

Data on the use of and reimbursement for SNF services are presented in Table 2.12. The data are based on bills for services rendered in a calendar year. Covered days of care for the aged decreased at an average annual rate of 4.7 percent from 1969 to 1986. The decline in the early 1970s resulted from administrative clarifications issued in 1969 to draw more clearly the distinction embedded in legislation between services rendered as a post-hospital benefit to further recovery from an episode requiring hospitalization (i.e., extended care) and custodial care. In 1986, the disabled accounted for only 3.6 percent of total Medicare-covered days in SNFs (derived from Table 2.12). From 1974 (the first year of coverage) to 1986, the number of covered days of care used by the disabled increased at an annual rate of 0.4 percent.

Among the aged, the decline in covered days of care in SNFs resulted in reimbursement declines from 1969 to 1972; only in 1973 did reimbursements begin to rise. SNF reimbursements for the aged rose at an average annual rate of 2.3 percent during the period 1969-86. In contrast, reimbursements for the disabled rose at an average annual rate of 7.2 percent during the period 1974-86.

Outpatient services

Reimbursements for outpatient care are shown in Table 2.13 and Figure 2.10. Outpatient services include those furnished by hospital outpatient departments, rural health clinics, community health centers, renal dialysis centers, and comprehensive outpatient rehabilitation facilities. Among aged and disabled enrollees combined, outpatient reimbursements grew more rapidly than reimbursements for any other service (as derived from data shown in this chapter). In 1986, the disabled accounted for more than one-fifth of outpatient reimbursements, reflecting the use by the ESRD population of renal dialysis services (derived from Table 2.13).

Home health services

Data on the use of and reimbursements for home health agency (HHA) services for the period 1969-86 are

Table 2.10

Inpatient use of short-stay hospitals under Medicare and general hospitals under Medicaid: 1967-86

Year	Discharges			Covered days of care			Reimbursements		
	Medicare[1]			Medicare			Medicare		
	Aged	Disabled	Medicaid[2]	Aged	Disabled	Medicaid[2]	Aged	Disabled	Medicaid
	Number in thousands						Amount in millions		
1967	5,228	NA	—	68,487	NA	—	$2,760	NA	—
1968	5,641	NA	—	75,589	NA	—	3,509	NA	—
1969	5,852	NA	—	77,246	NA	—	4,085	NA	—
1970	5,951	NA	—	75,578	NA	—	4,481	NA	—
1971	6,090	NA	—	74,298	NA	—	5,036	NA	—
1972	6,380	NA	—	75,284	NA	—	5,576	NA	—
1973	6,751	—	—	77,637	—	—	6,245	—	$2,660
1974	7,033	604	—	79,770	6,378	—	7,209	$621	2,887
1975	7,285	724	3,031	80,135	7,370	22,941	8,859	876	3,374
1976	7,607	863	3,287	82,916	8,661	14,935	10,589	1,183	3,904
1977	7,850	969	3,390	85,471	9,827	25,661	12,455	1,520	4,562
1978	8,133	1,060	3,708	87,033	10,581	25,521	14,182	1,834	4,992
1979	8,478	1,164	3,546	89,075	11,446	21,936	16,251	2,212	5,655
1980	9,051	1,228	3,203	94,422	12,090	24,089	19,460	2,639	6,412
1981	9,376	1,266	3,404	95,065	12,212	26,468	22,812	3,097	7,194
1982	9,913	1,310	2,915	98,268	12,389	21,552	27,223	3,642	7,670
1983	10,292	1,321	3,291	98,807	12,283	22,561	30,966	4,068	8,813
1984	9,927	1,222	3,414	85,369	10,386	23,185	[3]34,086	[3]4,390	8,848
1985	9,262	1,163	3,615	77,797	9,654	29,562	[3]35,109	[3]4,460	9,453
1986	9,064	1,158	3,670	76,740	9,611	29,336	[3]36,980	[3]4,729	10,312
				Percent					
ACRG[4]	2.9	5.6	1.8	0.6	3.5	2.3	14.6	18.4	11.0

[1] Discharge figures for 1986 differ from those in Table 3.12 because they were derived from different data sources and have different processing cutoff dates.

[2] Data for New York State are excluded from discharges and days of care for years prior to 1981. Discharges and covered days refer only to the nondually enrolled population (i.e., Medicaid recipients who are not also enrolled in Medicare).

[3] For 1984-86, includes estimates of prospective payment system passthrough expenditures as reported in the intermediary hospital payment report of the Health Care Financing Administration.

[4] Annual compound rate of growth.

NOTES: Medicare data are for calendar years; Medicaid data are for fiscal years.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.11

Medicare reimbursements for physicians' and other medical services and Medicaid payments for physicians' services: 1966-86

Year	Medicare reimbursements[1]		Medicaid payments
	Aged	Disabled	
	Amount in millions		
1966[2]	431.0	NA	—
1967	1,223.8	NA	—
1968	1,437.0	NA	—
1969	1,609.0	NA	—
1970	—	NA	—
1971	1,847.7	NA	—
1972	2,028.8	NA	—
1973	2,112.0	—	$925.9
1974	2,534.0	$206.2	1,083.4
1975	3,050.0	295.2	1,225.1
1976	3,633.0	389.1	1,368.9
1977	4,177.0	481.5	1,504.7
1978	5,145.0	556.5	1,554.4
1979	6,045.0	809.7	1,635.2
1980	7,361.4	996.9	1,874.6
1981	8,688.5	1,198.9	2,101.4
1982	10,310.8	1,671.4	2,085.5
1983	12,105.1	1,555.4	2,174.6
1984	13,218.0	1,548.9	2,220.4
1985	15,365.0	1,701.0	2,345.6
1986	16,972.3	1,853.9	2,548.2
	Percent		
ACRG[3]	[4]14.8	20.1	8.1

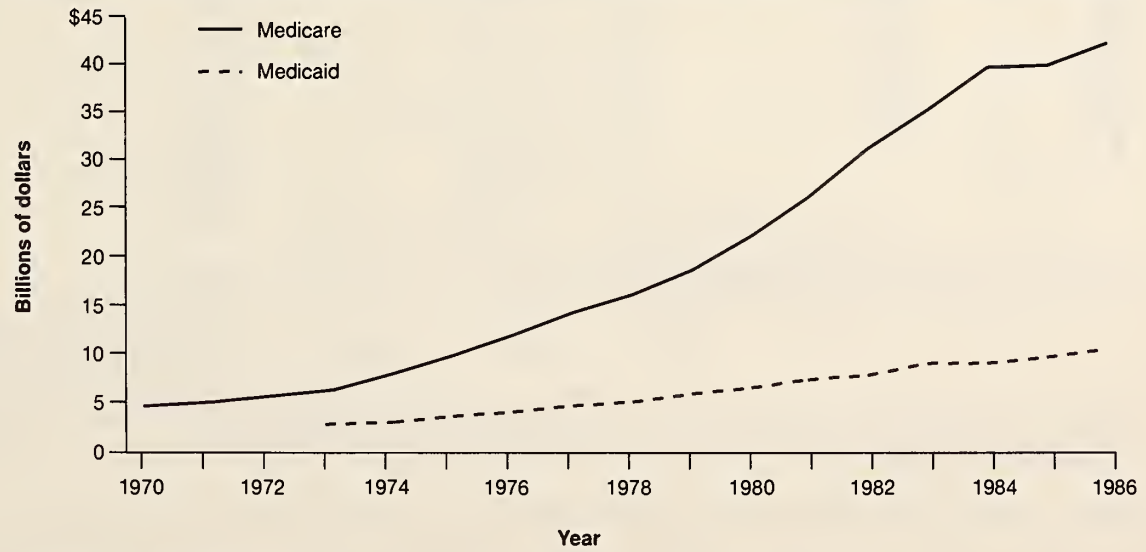
[1] Reimbursements for physicians' services, ambulance services, independent laboratory services, durable medical equipment, and prosthetic devices are included. Therefore, these are not directly comparable with Medicaid payments, which cover only physicians' services.
[2] July-December only.
[3] Annual compound rate of growth.
[4] ACRG computed for 1967-86.

NOTE: Medicare data are for calendar years; Medicaid data are for fiscal years.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

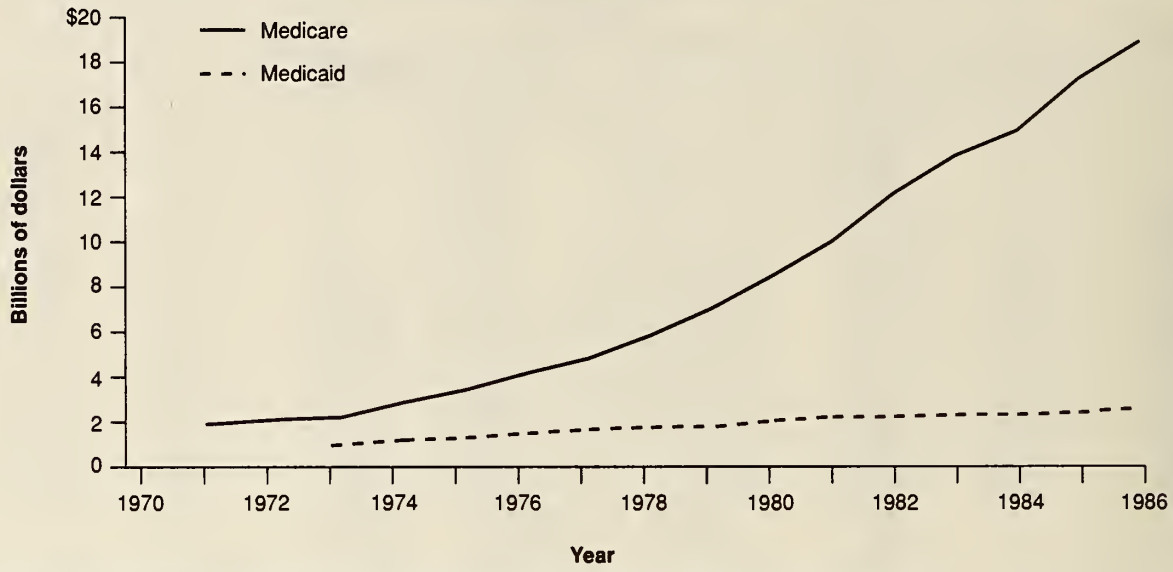
Figure 2.8

Medicare reimbursements and Medicaid payments for short-stay hospital services: 1970-86



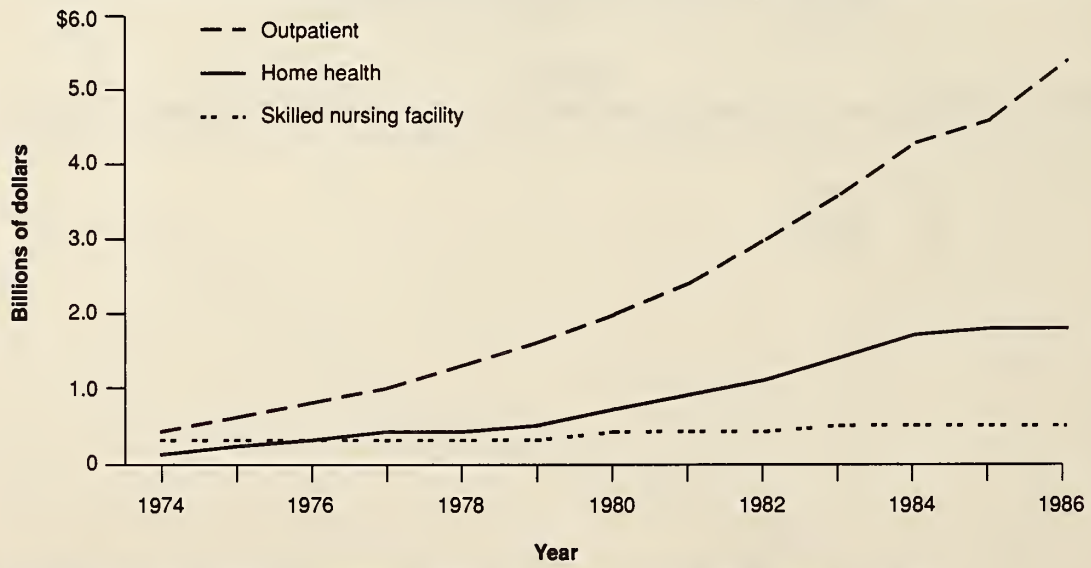
SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 2.9
Medicare reimbursements for physicians' and other medical services and Medicaid payments for physicians' services: 1970-86



SOURCE: Medicare statistics: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 2.10
Medicare reimbursements for selected services: Calendar years 1974-86



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.12

Medicare-covered days of care, covered charges, and reimbursements for skilled nursing facility services, by type of enrollee: Calendar years 1969-86

Year	Covered days of care		Covered charges		Reimbursements	
	Aged	Disabled	Aged	Disabled	Aged	Disabled
	Number in thousands		Amount in millions			
1969	17,572.5	NA	$432.2	NA	$335.0	NA
1970	10,697.1	NA	295.1	NA	225.6	NA
1971	7,481.1	NA	229.9	NA	178.7	NA
1972	6,628.0	NA	212.1	NA	164.1	NA
1973[1]	8,523.0	106.4	278.1	$4.0	209.8	$2.9
1974	8,687.9	277.0	322.9	11.8	237.6	8.3
1975	8,584.7	289.1	405.5	14.8	251.5	9.6
1976	9,406.7	316.6	448.7	17.6	293.5	11.2
1977	9,296.9	334.8	478.5	20.0	301.0	12.3
1978	8,764.5	320.8	500.5	21.1	307.7	12.7
1979	8,292.4	322.3	531.8	23.5	320.7	13.8
1980	8,394.4	318.0	597.3	25.5	352.7	14.4
1981	8,349.7	308.7	674.2	28.6	390.2	15.7
1982	8,519.2	294.7	776.1	30.5	421.1	15.7
1983	8,957.2	302.8	878.4	33.4	449.7	15.9
1984	9,308.8	314.3	1,008.7	38.2	481.7	16.8
1985	8,613.7	304.6	1,059.9	43.4	496.3	18.3
1986	7,814.9	291.8	1,126.1	49.8	492.9	19.2
			Percent			
ACRG[2]	-4.7	[3]0.4	5.8	[3]12.7	2.3	[3]7.2

[1] July-December only for disabled enrollees. Disabled enrollees were not covered by Medicare until July 1, 1973.
[2] Annual compound rate of growth.
[3] ACRG computed for 1974-86 only.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.13

Medicare reimbursements for outpatient services, by type of enrollee: Calendar years 1966-86

Year	Aged	Disabled
	Amount in millions	
1966[1]	$38.3	NA
1967	56.7	NA
1968	78.6	NA
1969	103.1	NA
1970	—	NA
1971	124.5	NA
1972	148.2	NA
1973	179.2	—
1974	252.5	$145.3
1975	374.4	221.2
1976	516.2	308.8
1977	649.0	391.7
1978	798.0	480.4
1979	1,001.4	587.9
1980	1,276.8	710.1
1981	1,597.2	817.3
1982	2,025.4	949.3
1983	2,603.6	1,007.3
1984	3,258.6	1,048.3
1985	3,585.9	1,023.6
1986	4,264.1	1,143.1
	Percent	
ACRG[2]	[3]25.5	18.8

[1] July-December only.
[2] Annual compound rate of growth.
[3] ACRG computed for 1967-86 only.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.14

Visits and reimbursements for home health services under Medicare: Calendar years 1969-86

Year	Visits in thousands	Reimbursements in millions
1969	8,500	$78.1
1970	6,000	61.5
1971	4,800	56.8
1972	5,200	65.9
1973	6,400	92.9
1974	8,200	144.3
1975	10,900	217.0
1976	13,500	294.6
1977	15,600	366.5
1978	17,100	426.9
1979	20,000	542.1
1980	22,600	665.7
1981	26,200	859.6
1982	31,400	1,121.0
1983	37,600	1,426.6
1984	41,400	1,703.6
1985	40,500	1,794.7
1986	38,800	1,807.7
	Percent	
ACRG[1]	9.3	20.3

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

presented in Table 2.14. During this period, the number of home visits increased more than fourfold, from 8.5 million to 38.8 million. Program payments increased from $78.1 million to $1.8 billion. The rapid increase in visits and reimbursements since 1980 reflects the implementation of the Omnibus Reconciliation Act of 1980 (Public Law 96-499), which improved HHA benefits effective July 1981. The act provided for unlimited HHA visits for enrollees having HI and eliminated the 3-day prior hospitalization requirement to receive services. For the relatively few enrollees with SMI but no HI coverage, the act provided unlimited visits and eliminated the need to meet the SMI deductible before Medicare paid for services.

Services to ESRD enrollees

In Table 2.15, information is presented on reimbursements, enrollment, and per capita reimbursements from 1974 through 1986 for enrollees with end stage renal disease. (More information on Medicare coverage can be found in Health Care Financing Administration, 1987). In 1974, the first full year of coverage of ESRD patients, total Medicare reimbursements for the ESRD program were $240 million. By 1986, reimbursements had risen to almost $2.5 billion, more than ten times the amount in 1974, or an annual growth rate of 21.5 percent. However, the rate of growth has slowed considerably in recent years. From 1974 to 1975, the rate of growth was 58 percent, but from 1985 to 1986 the growth had slowed to 12.7 percent.

This pattern of growth in reimbursements is largely caused by the growth in the ESRD population. There were 16,000 ESRD enrollees in 1974. By 1986, this total was 117,100, more than seven times as great. Enrollment increases were also greatest in the early years of the program. Although the overall annual growth rate from 1974 to 1986 was 18.0 percent, the rate was 41.9 percent from 1974 to 1975 but only 7.8 percent from 1985 to 1986.

The growth rate in ESRD enrollees reflects the unique nature of this Medicare population. Before Medicare covered ESRD patients, most people with ESRD died because of lack of funding for the expensive dialysis maintenance therapy or for kidney transplantation operations. Thus, in July 1973, when the ESRD program began, it mainly served people whose onset of ESRD occured in 1973. In 1974, the program served people whose ESRD began in 1974 plus survivors whose treatment began in 1973. In 1975, new ESRD patients were added to cohorts from the two previous years, and so on. As enrollment has grown, the number of deaths among the carryover population has begun to approach the number of new entries because annual mortality, even with dialysis, is about 20 percent. Thus, the overall growth rate has slowed considerably (Health Care Financing Administration, 1990).

Reimbursements per ESRD enrollee rose from $15,000 in 1974 to $21,264 in 1986. The annual growth rate of only 3.0 percent results largely from a cap on the allowed charge per dialysis since the program began. Since the ESRD program's inception, charges for renal dialysis have generally been held to a maximum amount per treatment. Thus, the accelerating rate of SMI reimbursements among the disabled primarily reflects increases in the number of ESRD patients rather than increases in reimbursement per patient. Dialysis reimbursements amount to about 50 percent of reimbursements for ESRD patients. The remaining 50 percent is mostly for inpatient hospital care and physicians' services, which have not been subject to a reimbursement cap (Health Care Financing Administration, 1990). A second factor limiting the growth of the ESRD program is the increasing success

Table 2.15

Medicare reimbursements, enrollees, and reimbursements per enrollee for persons with end stage renal disease: Calendar years 1974-86

Year	Reimbursements		Enrollees [1]		Reimbursement per enrollee	
	Amount in millions	Percent change	Number in thousands	Percent change	Amount	Percent change
1974	$240	NA	16.0	NA	$15,000	NA
1975	380	58.3	22.7	41.9	16,740	11.6
1976	540	42.1	28.9	27.3	18,685	11.6
1977	670	24.1	38.0	31.5	17,632	-5.6
1978	840	25.4	47.6	25.3	17,647	0.1
1979	1,060	26.2	56.1	17.9	18,895	7.1
1980	1,310	23.6	64.2	14.4	20,405	8.0
1981	1,540	17.6	71.7	11.7	21,478	5.3
1982	1,740	13.0	80.6	12.4	21,588	0.5
1983	1,990	14.4	90.6	12.4	21,965	1.7
1984	2,080	4.5	99.9	10.3	20,884	-4.9
1985	2,210	6.3	108.6	8.7	20,350	-2.6
1986	2,490	12.7	117.1	7.8	21,264	4.5
			Percent			
ACRG[2]	21.5	NA	18.0	NA	3.0	NA

[1] Includes enrollees entitled to Medicare benefits as aged or disabled persons and persons entitled by the provisions of Section 2991 of Public Law 92-603 as "renal only."

[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Data from the End Stage Renal Disease Archival Reimbursement Abstract.

of transplantation. Patients with a functioning kidney graft incur considerably lower medical expenses than do patients on dialysis. In 1978, only 11 percent of the Medicare ESRD population had a functioning kidney graft. By 1986, because of greater numbers of transplants and a greater transplant success rate, 20 percent had a functioning graft (Health Care Financing Administration, 1990).

Parceling out the growth in total ESRD reimbursements into the two components of enrollment and per capita reimbursements shows that 86 percent of the growth is caused by the increase in the enrolled population and only 14 percent by the increase in reimbursements per enrollee. (The parceling method is described in Klarman et al., 1970.)

Medicaid services

Trends in Medicaid payments for SNF and ICF services are shown in Figure 2.11. Data on Medicaid payments for hospital outpatient services, home health services, and prescription drugs are shown in Figure 2.12. Detailed information on trends in these services is presented in Tables 2.16-2.20.

Skilled nursing facilities and intermediate care facilities

Data on use of and payments to SNFs under Medicaid are shown in Table 2.16. From 1973 to 1986, recipients in SNFs and total days of care declined at annual rates of 1.3 and 1.1 percent, respectively. Although the overall trend in the number of recipients and days of care has been downward, year-to-year fluctuations have been notable. In spite of these fluctuations in use, payments grew steadily at an annual rate of 8.5 percent, to about $5.7 billion in 1986.

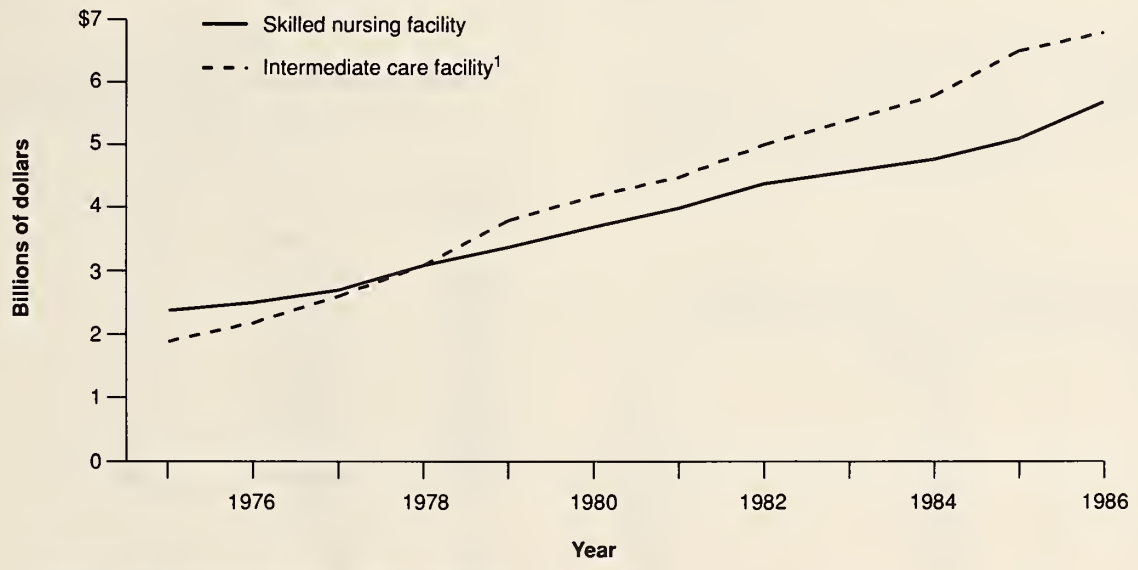
Data on trends in the use of and payments to ICFs during the period 1975-86 are presented in Table 2.17. Payments grew at an annual rate of 12.3 percent, to almost $6.8 billion in 1986. The numbers of recipients and days of care grew more slowly, 1.8 and 2.4 percent per year, respectively. Note that these large payments for SNF and ICF services identify Medicaid as the primary public payer for long-term care services.

Hospital outpatient services

Data on Medicaid utilization of hospital outpatient services during the period 1973-86 are reported in

Figure 2.11

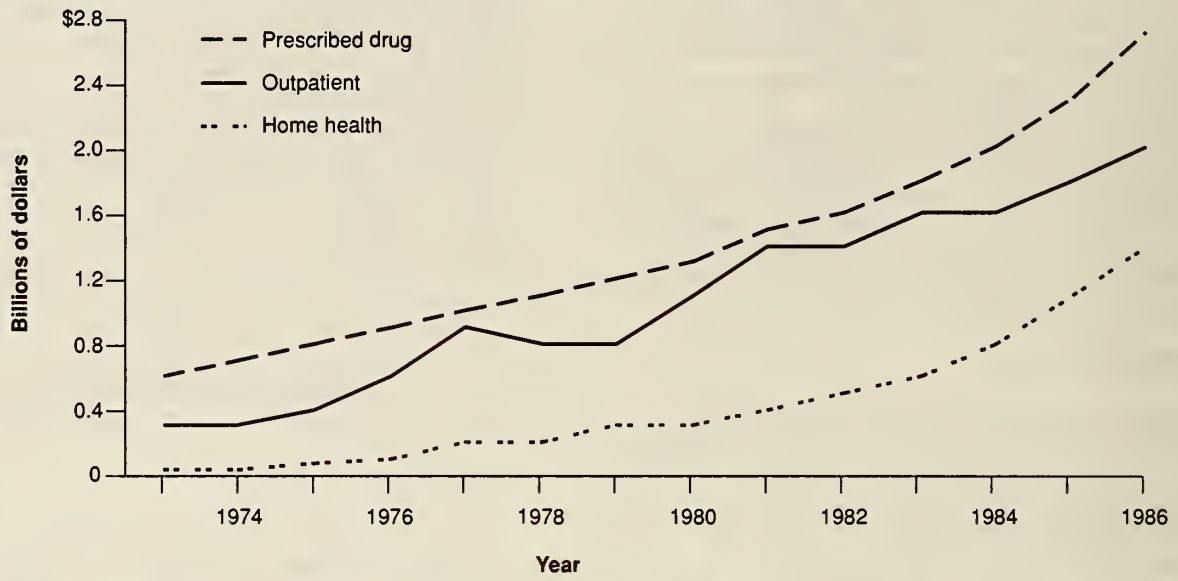
Medicaid payments for nursing facility services, by type of service: Fiscal years 1975-86



[1]Excludes intermediate care facilities for the mentally retarded.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 2.12
Medicaid payments for selected services: Fiscal years 1973-86



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.16

Medicaid recipients, days of care, and payments for skilled nursing facility services: Fiscal years 1973-86

Year	Recipients	Days of care	Payments in millions
	Number in thousands		
1973[1]	678	133,905.0	$1,958.9
1974[2]	661	130,547.5	2,001.9
1975	630	120,672.5	2,434.2
1976	637	122,252.5	2,475.6
1977	641	124,622.5	2,691.2
1978	639	125,412.5	3,125.0
1979	610	117,117.5	3,379.5
1980	609	120,277.5	3,685.2
1981	623	125,412.5	4,035.4
1982	559	110,205.0	4,426.7
1983	574	123,114.5	4,621.0
1984	559	111,383.9	4,810.3
1985	547	111,670.8	5,072.5
1986	571	116,043.9	5,655.7
		Percent	
ACRG[3]	-1.3	-1.1	8.5

[1] Includes intermediate care facilities in Michigan.
[2] Includes intermediate care facilities in West Virginia, Missouri, and North Carolina.
[3] Annual compound rate of growth.

NOTE: Estimates were made for States with missing data. Therefore, figures may differ from those in Table 4.12.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.17

Medicaid recipients, days of care, and payments for intermediate care facility services: Fiscal years 1975-86

Year	Recipients	Days of care	Payments in millions
	Number in thousands		
1975	682	167,184.8	$1,885.0
1976	724	178,812.8	2,208.5
1977	754	193,283.2	2,637.2
1978	740	190,957.6	3,104.4
1979	766	194,316.8	3,773.2
1980	789	203,877.6	4,201.7
1981	762	199,484.8	4,506.7
1982	765	197,934.4	4,979.0
1983	793	201,199.3	5,380.6
1984	796	202,133.6	5,822.5
1985	829	207,098.1	6,525.8
1986	828	217,972.2	6,780.3
		Percent	
ACRG[1]	1.8	2.4	12.3

[1] Annual compound rate of growth.

NOTES: Data exclude intermediate care facilities for the mentally retarded. Data for 1973 and 1974 are not available.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.18

Medicaid recipients and payments for hospital outpatient services: Fiscal years: 1974-86

Year	Recipients in thousands	Payments in millions
1973	5,295.4	$267.6
1974	5,544.5	322.0
1975	7,436.8	372.8
1976	8,482.2	555.3
1977	8,618.9	876.6
1978	8,628.0	834.6
1979	7,710.4	847.4
1980	9,704.9	1,101.1
1981	10,017.9	1,409.1
1982	9,852.5	1,437.7
1983	10,068.6	1,574.2
1984	10,034.5	1,646.3
1985	10,072.5	1,789.1
1986	10,711.1	1,982.9
	Percent	
ACRG[1]	5.6	16.7

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.18. The number of recipients grew 5.6 percent annually from 1973 through 1986, while payments increased about three times the rate of the number of recipients, to almost $2.0 billion in 1986.

Home health services

As shown in Table 2.19, home health care has been one of the fastest growing services covered by Medicaid. From 1973 through 1986, the number of recipients increased at an average annual rate of 13.9 percent. Payments grew at an even higher rate, 35.8 percent per year, to almost $1.4 billion in 1986.

Table 2.19

Medicaid recipients and payments for home health services: Fiscal years 1973-86

Year	Recipients in thousands	Payments in millions
1973	109.9	$25.4
1974	134.7	31.1
1975	342.8	70.0
1976	319.2	134.1
1977	370.8	180.0
1978	376.5	210.0
1979	358.9	263.5
1980	392.4	332.0
1981	401.7	427.8
1982	377.3	495.5
1983	421.8	597.2
1984	437.7	773.6
1985	535.3	1,119.7
1986	593.5	1,352.1
	Percent	
ACRG[1]	13.9	35.8

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.20

Selected measures of use of prescription drugs under Medicaid: Fiscal years 1973-86

Year	Recipients	Prescriptions	Number of prescriptions per recipient	Payments im millions
	Number in thousands			
1973	12,116.2	127,293.4	10.5	$609.3
1974	14,240.0	143,179.5	10.1	712.6
1975	14,155.4	154,701.1	10.9	814.9
1976	14,883.3	170,287.8	11.4	939.6
1977	15,369.9	173,891.1	11.3	1,018.2
1978	15,187.8	176,991.2	11.7	1,081.7
1979	14,282.9	177,657.2	12.4	1,196.3
1980	13,707.4	169,457.2	12.4	1,318.3
1981	14,255.7	176,215.0	12.4	1,534.7
1982	13,546.7	175,830.8	13.0	1,598.9
1983	13,731.8	177,436.8	12.9	1,771.2
1984	13,934.6	181,060.8	13.0	1,968.2
1985	13,920.6	190,126.5	13.7	2,315.5
1986	14,703.8	—	—	2,691.9
		Percent		
ACRG [1]	1.5	3.4	2.2	12.1

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 2.21

Hospital insurance and supplementary medical insurance cost-sharing deductible and coinsurance amounts for Medicare aged and disabled enrollees: United States, calendar years 1977-86

Type of coverage and year	Cost sharing											
	Total		Deductible		Coinsurance[1]		Total		Deductible		Coinsurance[1]	
	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled
Hospital Insurance			Amounts in millions						Amount per enrollee[2]			
1977	$972	$119	$756	$88	$216	$31	$42	$46	$33	$34	$9	$12
1978	1,161	150	907	112	254	38	49	54	38	40	11	14
1979	1,333	179	1,035	133	298	46	55	62	43	46	12	16
1980	1,595	212	1,239	156	356	56	65	72	50	53	14	19
1981	1,836	244	1,434	181	402	63	73	82	57	61	16	21
1982	2,588	325	2,037	240	551	85	101	110	79	81	21	29
1983	2,886	364	2,237	273	649	91	108	125	84	94	24	31
1984	3,032	370	2,482	293	550	77	112	128	91	102	20	27
1985	3,098	362	2,575	291	523	71	123	121	102	97	21	24
1986	3,746	443	3,207	362	539	81	135	155	116	127	19	29
						Percent						
ACRG[3]	16.2	15.7	17.4	17.0	10.7	11.3	13.9	14.5	15.0	15.8	8.7	10.3
Supplementary medical Insurance			Amounts in millions						Amount per enrollee[2]			
1977	$2,210	$305	$966	$81	$1,244	$224	$96	$129	$42	$34	$54	$95
1978	2,469	369	1,009	90	1,460	279	105	146	43	36	62	110
1979	2,801	445	1,059	99	1,742	346	117	168	44	37	73	131
1980	3,213	528	1,102	105	2,111	423	131	195	45	39	86	156
1981	3,721	617	1,154	108	2,567	509	148	225	46	39	102	186
1982	4,691	747	1,507	141	3,184	606	183	275	59	52	124	223
1983	5,131	748	1,475	141	3,656	607	195	279	56	53	139	226
1984	5,368	771	1,396	136	3,972	635	201	291	52	51	148	240
1985	6,223	791	1,514	137	4,709	654	222	264	54	46	168	218
1986	6,848	859	1,564	141	5,284	718	248	322	57	53	191	269
						Percent						
ACRG[3]	13.4	12.2	5.5	6.4	17.4	13.8	11.1	10.7	3.5	5.1	15.1	12.3

[1] Includes coinsurance payments for both hospitals and skilled nursing facilities.
[2] Based on average annual enrollment.
[3] Annual compound rate of growth.

NOTES: Excludes cost-sharing payments of end stage renal disease patients. Data may be revised.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Office of Research.

Prescription drugs

Data on use of and payments for prescription drugs under Medicaid are shown in Table 2.20. Both the number of recipients and number of prescriptions grew significantly during the period from 1973, with the rate of growth in the number of prescriptions rising at more than double that of recipients. The number of prescriptions per recipient grew at a rate of 2.2 percent per year, increasing from 10.5 per recipient in 1973 to 13.7 per recipient in 1986. Payments for prescriptions grew steadily at an annual rate of 12.1 percent, to almost $2.7 billion.

Medicare cost sharing

Medicare cost sharing (coinsurance and deductibles) by HI and SMI enrollees are shown in Table 2.21. These cost-sharing amounts do not include amounts due to physicians on unassigned claims that exceed the charges allowed by Medicare. Aged and disabled Medicare enrollees who used the HI program (hospitals and SNFs) incurred $4.2 billion in cost-sharing expenses in 1986. In 1986, the HI deductible accounted for 85 percent of HI enrollee liabilities for the aged and the disabled combined (derived from Table 2.21).

The disabled, excluding persons entitled to Medicare solely because of ESRD, had HI liabilities per enrollee that were somewhat higher than those of the aged. As can be derived from Table 2.21, from 1977 to 1986, total HI liabilities of aged and disabled enrollees rose at an average annual rate of nearly 16.1 percent. The increase was primarily caused by rising hospital charges, as reflected in the increase in the deductible from $124 per benefit period in 1977 to $492 in 1986 and the accompanying increase in the coinsurance amount. The Medicare copayment provisions are described in more detail in the next chapter.

Total liabilities for SMI services in 1986 are estimated at almost $7.7 billion. Because the SMI deductible is a fixed annual amount, $60 for the years 1973-81 and $75 since 1982, deductibles accounted for only 22 percent of the total SMI liabilities incurred by aged and disabled enrollees in 1986. As derived from Table 2.21, total SMI liabilities increased at an average annual rate of 13.3 percent from 1977 to 1986.

Personal health care expenditures

Personal health care expenditures in the United States for the direct provision of medical care goods and services for selected calendar years 1965-86 are shown in Table 2.22. The data are estimates made by HCFA's Office of National Cost Estimates (Health Care Financing Administration, 1987a). Personal health care expenditures in 1986 comprised direct patient payments of $116.1 billion and indirect, or third-party, payments of $287.9 billion. Third-party payments consisted of private health insurance and other private funds, $127.9 billion, and public funds, $160.0 billion. Public funds consisted of $121.8 billion in Federal funds and $38.1 billion in State and local funds. Medicare funds, $76.0 billion, and Medicaid funds, $43.6 billion, are shown separately in the table.

In 1965, before the Medicare and Medicaid programs began, direct patient payments were $91 per capita and accounted for 51.6 percent of total payments for personal health care services. Private health insurance paid 24.2 percent of personal health care expenditures, the Federal Government paid 10.1 percent, and State and local governments paid 11.9 percent. By 1986, although direct patient payments had risen to $466 per capita, it decreased to 28.7 percent of the payments for personal health care services. Private health insurance payments rose from $42 to $493 per capita in the 1965-86 period and increased from 24.2 to 30.4 percent of expenditures. The rise in the proportion of private health insurance payments resulted from persons seeking to reduce the risk of high out-of-pocket payments. Reflecting primarily the institution of the Medicare and Medicaid programs, Federal personal health care expenditures rose from $18 to $488 per capita in the same period and its share from 10.1 to 30.2 percent. State and local expenditures were a decreasing share of payments, falling from 11.9 percent in 1965 to 9.4 percent in 1986. Medicare payments rose from 10.9 percent of total payments in 1970 to 18.8 percent in 1986. In the same period, Medicaid payments increased at a slower rate, from 8.0 percent to 10.8 percent of total payments. As derived from the table, the Medicare and Medicaid programs combined accounted for about three-quarters of all public spending for personal health care in 1986. Medicare accounted for 47.5 percent of all public payments, Medicaid accounted for 27.3 percent of all public payments, and the remaining payments, 25.2 percent, were mainly from State and local sources, the Veterans Administration, and the Department of Defense.

Table 2.22

Amount, per capita amount, and percent distribution of personal health care expenditures, by source of funds: Selected calendar years 1965-86

Year	Total	Direct patient payments	Third-party payments							
			All third parties	Private health insurance	Other private funds	Government				
						Total	Federal	State and local	Medicare[1]	Medicaid[2]
					Amount in billions					
1965	$35.9	$18.5	$17.3	$8.7	$0.8	$7.9	$3.6	$4.3	—	—
1970	65.4	26.5	38.9	15.3	1.1	22.4	14.5	7.9	$7.1	$5.2
1975	117.1	38.1	79.0	31.2	1.6	46.3	31.4	14.9	15.6	13.5
1980	219.7	63.0	156.7	67.5	2.7	86.5	62.5	24.0	35.7	25.2
1984	341.1	97.8	243.3	104.9	4.3	134.1	100.9	33.2	62.9	36.3
1985	371.4	105.6	265.8	113.5	4.9	147.5	112.6	34.8	70.5	39.8
1986	404.0	116.1	287.9	122.9	5.0	160.0	121.8	38.1	76.0	43.6
					Per capita amount					
1965	$176	$91	$85	$42	$4	$39	$18	$21	(3)	(3)
1970	304	123	181	71	5	104	68	37	(3)	(3)
1975	521	169	351	139	7	206	140	66	(3)	(3)
1980	934	268	666	287	11	367	266	102	(3)	(3)
1984	1,394	400	994	429	18	548	412	136	(3)	(3)
1985	1,504	428	1,076	460	20	597	456	141	(3)	(3)
1986	1,620	466	1,154	493	20	641	488	153	(3)	(3)
					Percent distribution					
1965	100.0	51.6	48.4	24.2	2.2	22.0	10.1	11.9	—	—
1970	100.0	40.5	59.5	23.4	1.7	34.3	22.2	12.1	10.9	8.0
1975	100.0	32.5	67.5	26.7	1.3	39.5	26.8	12.7	13.3	11.6
1980	100.0	28.7	71.3	30.7	1.2	39.4	28.4	10.9	16.2	11.5
1984	100.0	28.7	71.3	30.7	1.3	39.3	29.6	9.7	18.4	10.7
1985	100.0	28.4	71.6	30.6	1.3	39.7	30.3	9.4	19.0	10.7
1986	100.0	28.7	71.3	30.4	1.2	39.6	30.2	9.4	18.8	10.8

[1] Subset of Federal funds.
[2] Subset of Federal, State, and local funds.
[3] Calculation of per capita estimates is inappropriate.

NOTES: Per capita amounts are based on July 1 social security area population estimates. Totals do not necessarily equal the sum of rounded components.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

3. Medicare: Description and data

Detailed information on the Medicare program is presented in this chapter. The program was enacted on July 30, 1965, as title XVIII of the Social Security Act to finance health care for the aged. Benefits began on July 1, 1966. The Medicare program (Health Insurance for the Aged) was substantially expanded by the 1972 Amendments to the Social Security Act (Public Law 92-603). These amendments (effective July 1, 1973) extended Medicare coverage to disabled beneficiaries of the social security and railroad retirement programs and to persons requiring dialysis or a kidney transplant for end stage renal disease. The official name of the Medicare program was then changed to Health Insurance for the Aged and Disabled. Major changes in the Medicare law through the Omnibus Budget Reconciliation Act (OBRA) of 1986 (Public Law 99-509), which became law on October 21, 1986, are described in this report.

The Secretary of the Department of Health and Human Services (DHHS) has overall responsibility for the Medicare program. Within DHHS, the Health Care Financing Administration (HCFA) administers Medicare. Medicare consists of two separate but complementary insurance programs: hospital insurance (HI) and supplementary medical insurance (SMI). HI covers inpatient hospital, skilled nursing facility, and home health services, and SMI covers physicians' and related services for eligible persons who voluntarily pay premiums or whose premiums are paid for them.

In the next four sections, eligibility standards, benefits, financing, and administration are described for both HI and SMI. Analysis of the distribution of benefits is presented according to the following formula:

$$\frac{\text{Persons served}}{\text{Enrollees}} \times \frac{\text{Reimbursements}}{\text{Persons served}} = \frac{\text{Reimbursements}}{\text{Enrollees}}$$

where:

Persons served are persons who exceeded deductibles (HI or SMI) and were reimbursed by Medicare for services received;
Persons served/enrollees is the proportion of enrollees who exceeded deductibles and were reimbursed for covered services;
Reimbursements/persons served is the average Medicare reimbursement for persons who received Medicare reimbursements; and
Reimbursements/enrollees is the average Medicare reimbursement for a population group.

In the final sections of this chapter, the Medicare program's arrangements with risk-group health plans are discussed and the Medicare statistical system is described.

Eligibility

All persons 65 years of age or over who are entitled to monthly social security cash benefits or payments from the railroad retirement system are eligible for benefits under the HI program. Since July 1, 1973, disabled persons entitled to cash benefits under the social security or railroad retirement programs have also been eligible for HI benefits. A person must be disabled for 5 calendar months before disability benefits begin and then be entitled to 24 months of cash benefits before becoming eligible for HI benefits. Thus, Medicare coverage begins the 30th month after the first full calendar month of disability.

HI protection also extends to persons who have end stage renal disease (ESRD) and require renal dialysis or a kidney transplant if they are currently insured, entitled to monthly social security benefits, or are the spouses or dependent children of such insured persons. Eligibility for coverage begins the third month after renal dialysis treatments begin or before this qualifying dialysis period for ESRD enrollees who receive kidney transplants without starting or receiving dialysis in preparation for transplantation. Eligibility ends with the 36th month after a person receives a kidney transplant or after dialysis treatment has been terminated.

The 1972 Amendments to the Social Security Act, effective July 1973, permit most persons 65 years of age or over who are ineligible for HI coverage to enroll voluntarily by paying a monthly premium. This "premium-HI" was set at $234 a month for 1988 and represents the actuarial cost of HI. To obtain premium-HI, the enrollee must also obtain SMI coverage.

Persons entitled to benefits under the HI program and most other persons 65 years of age or over may voluntarily enroll in SMI. Only the aged can enroll in SMI without being eligible for HI; disabled persons may not. The Omnibus Budget Reconciliation Act of 1981, effective October 1, 1981, instituted a general enrollment period, which occurs from January through March each year. Coverage becomes effective July 1. Persons may terminate SMI enrollment by not paying premiums. A person may reenroll by paying a surcharge of 10 percent for every 12 months that he or she could have been enrolled. Coverage resumes on July 1. Under the State buy-in system, a State government may enroll and pay SMI premiums for eligible aged and disabled individuals who are also covered by the Medicaid program.

Data on the total number of aged and disabled persons enrolled in Medicare (HI and/or SMI) in 1985 and 1986 are shown in Table 3.1. Total Medicare enrollees, 91 percent of whom were aged, numbered 31.7 million in 1986. Ninety-eight percent of the aged were enrolled in both HI and SMI or only in HI. The remainder, 534,200 aged who were ineligible for HI, were enrolled only in SMI. Ninety-two percent of disabled HI enrollees were also enrolled in SMI.

In Table 3.2, the number of aged and disabled enrollees in 1986 for both HI and SMI is shown by census region and division. For both aged and disabled groups, the greatest number of enrollees resided in the South, and the smallest number resided in the West.

Table 3.1

Number of aged and disabled Medicare enrollees, by type of coverage: July 1, 1985 and 1986

Type of enrollee	Hospital insurance and/or supplementary medical insurance		Hospital insurance		Supplementary medical insurance	
	1985	1986	1985	1986	1985	1986
	Number in thousands					
Total	31,082.8	31,749.7	30,589.5	31,215.5	29,988.8	30,589.7
Aged [1]	28,175.9	28,791.2	27,682.6	28,257.0	27,310.9	27,862.7
Disabled [2]	2,906.9	2,958.5	2,906.9	2,958.5	2,677.9	2,727.0

[1] All enrollees 65 years of age or over, including enrollees with end stage renal disease (ESRD).
[2] All enrollees under 65 years of age, including enrollees with ESRD.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.2

Number of aged and disabled Medicare enrollees, by type of coverage, census region, and census division: July 1, 1986

Census region and division	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Total	Aged	Disabled [1]	Total	Aged	Disabled [1]	Total	Aged	Disabled [1]
All areas	31,749,708	28,791,162	2,958,546	31,215,529	28,257,004	2,958,525	30,589,728	27,862,737	2,726,991
United States [2]	31,090,161	28,237,305	2,852,856	30,557,513	27,704,677	2,852,836	30,277,977	27,603,434	2,674,543
Northeast	7,134,947	6,529,827	605,120	7,022,716	6,417,598	605,118	6,938,053	6,376,215	561,838
New England	1,800,110	1,656,698	143,412	1,778,342	1,634,931	143,411	1,742,591	1,611,529	131,062
Middle Atlantic	5,334,837	4,873,129	461,708	5,244,374	4,782,667	461,707	5,195,462	4,764,686	430,776
North Central	7,951,672	7,258,951	692,721	7,871,602	7,178,879	692,713	7,766,812	7,121,590	645,222
East North Central	5,434,116	4,927,555	506,561	5,372,766	4,866,212	506,554	5,304,096	4,832,375	471,721
West North Central	2,517,556	2,331,396	186,160	2,498,836	2,312,667	186,159	2,462,716	2,289,215	173,501
South	10,492,953	9,415,228	1,077,725	10,273,031	9,195,314	1,077,717	10,218,012	9,199,376	1,018,636
South Atlantic	5,522,647	4,972,867	549,780	5,412,077	4,862,301	549,776	5,384,286	4,865,601	518,685
East South Central	2,034,688	1,779,828	254,860	1,989,075	1,734,215	254,860	1,983,207	1,740,635	242,572
West South Central	2,935,618	2,662,533	273,085	2,871,879	2,598,798	273,081	2,850,519	2,593,140	257,379
West	5,489,873	5,015,160	474,713	5,370,968	4,896,257	474,711	5,337,166	4,890,666	446,500
Mountain	1,416,585	1,296,326	120,259	1,400,052	1,279,793	120,259	1,372,670	1,261,242	111,428
Pacific	4,073,288	3,718,834	354,454	3,970,916	3,616,464	354,452	3,964,496	3,629,424	335,072

[1] Includes disabled enrollees under age 65 with end stage renal disease and enrollees with end stage renal disease only.
[2] Includes 50 States, District of Columbia, and unknown residence.

NOTE: This table is based on data recorded in the Medicare health insurance master file on March 27, 1987.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Detailed information on the distribution of HI and SMI benefits for aged and disabled enrollees is presented in Tables 3.3 and 3.4 respectively. Much larger proportions of aged and disabled enrollees received SMI benefits than HI benefits, (persons served per 1,000 enrollees). For both groups, average reimbursements per person served were higher for HI than for SMI. The proportions of both aged and disabled enrollees receiving benefits were higher for older age groups for both HI and SMI.

Benefits

Overview

The following description of the Medicare benefits reflects the program as of 1986. The experiences of the program under the provisions of the Medicare Catastrophic Coverage Act of 1988, which was repealed in 1989, are not reflected in this report. Some provisions went into effect on January 1, 1989: unlimited hospitalization after payment of a single annual deductible, annual coverage of up to 150 days of SNF services with copayments for only the first 8 days, and unlimited hospice care for beneficiaries recertified as terminally ill after 210 days of care in a hospice. These provisions ended with the repeal.

The HI program covers inpatient hospital care and post-hospital care in skilled nursing facilities (SNFs). The program also covers home health agency (HHA) services for persons confined to the home who need skilled nursing care or physical or speech therapy. To be covered, services must be provided by institutions and organizations that have been certified as qualified providers and that have agreements to participate in the program. Exceptions to this rule are made for emergency services.

The Omnibus Reconciliation Act (ORA) of 1980 (Public Law 96-499), effective July 1, 1981, eliminated the HI requirement for prior hospitalization and the limits on home health visits. Under the new law, all home health visits are covered by the HI program unless a beneficiary has SMI coverage only. In such cases, home health visits are covered by the SMI program.

The SMI program covers a variety of medical services and supplies furnished by physicians or other health care professionals in connection with physicians' services. It also covers outpatient and home health services.

Counts of the number of institutional providers participating in Medicare from 1976 through 1986 are presented in Table 3.5. The number of HHAs increased 2.5 times in this period. This was partly the result of ORA 1980, which permitted HHAs to operate in States

Table 3.3

Persons served and reimbursements for aged Medicare enrollees, by type of coverage and demographic characteristics: Calendar year 1986

Characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Persons served per 1,000 enrollees	Reimbursements[1]		Persons served per 1,000 enrollees	Reimbursements[1]		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	731.7	$2,887	$2,112	213.8	$6,539	$1,398	750.8	$1,018	$764
Age									
65-69 years	658.7	2,373	1,563	151.4	6,553	992	684.7	898	615
70-74 years	720.7	2,802	2,019	191.8	6,833	1,310	732.6	1,026	751
75-79 years	767.6	3,100	2,380	235.4	6,683	1,573	779.5	1,110	865
80-84 years	807.9	3,310	2,674	285.2	6,389	1,822	820.2	1,114	913
85 years or over	827.0	3,477	2,875	336.7	6,062	2,041	864.4	1,026	886
Sex									
Male	691.1	3,294	2,276	223.1	6,872	1,533	713.5	1,115	795
Female	758.7	2,639	2,002	207.5	6,298	1,307	775.4	960	744
Race[2]									
White	737.7	2,857	2,107	214.6	6,460	1,386	755.0	1,009	762
Other	682.5	3,223	2,199	209.1	7,342	1,534	715.4	1,123	803
Census region									
Northeast	775.4	2,947	2,284	213.4	7,104	1,515	790.3	1,030	814
North Central	729.1	2,913	2,123	220.4	6,588	1,452	738.8	949	700
South	735.5	2,763	2,032	229.9	5,855	1,346	748.0	982	734
West	727.0	3,064	2,227	189.1	7,408	1,400	738.3	1,194	881

[1] Hospital insurance reimbursment amounts are based on expenditures reported on Health Care Financing Administration (HCFA) billing form HCFA-1450 plus prospective payment system short-stay hospital inpatient passthrough expenditures reported on HCFA intermediary benefit payment report.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.4

Persons served and reimbursements for disabled Medicare enrollees, by type of coverage and demographic characteristics: Calendar year 1986

Characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Persons served per 1,000 enrollees	Reimbursements [1]		Persons served per 1,000 enrollees	Reimbursements [1]		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	674.0	$4,038	$2,721	224.1	$7,631	$1,710	721.6	$1,522	$1,097
Age									
Under 35 years	618.7	4,233	2,618	188.8	8,652	1,633	660.0	1,614	1,065
35-44 years	616.4	4,009	2,471	189.6	7,931	1,504	668.0	1,591	1,062
45-54 years	659.5	4,138	2,728	223.6	7,519	1,681	710.9	1,610	1,144
55-59 years	694.2	4,116	2,857	242.7	7,468	1,812	744.2	1,525	1,134
60-64 years	732.4	3,859	2,826	250.2	7,285	1,822	775.5	1,390	1,077
Sex									
Male	622.5	4,018	2,501	209.5	7,688	1,610	671.4	1,453	975
Female	763.9	4,068	3,107	249.6	7,547	1,883	806.9	1,619	1,306
Race [2]									
White	674.9	3,823	2,580	222.0	7,418	1,646	724.2	1,401	1,014
Other	670.6	4,924	3,301	233.0	8,448	1,968	711.6	2,019	1,437
Census region									
Northeast	725.6	4,169	3,024	223.4	8,305	1,855	771.7	1,632	1,259
North Central	689.3	4,034	2,780	231.5	7,942	1,838	730.3	1,385	1,011
South	666.3	3,882	2,586	243.5	6,746	1,642	696.2	1,434	998
West	704.1	4,398	3,096	205.0	8,950	1,834	741.2	1,810	1,341

[1]Hospital insurance reimbursment amounts are based on expenditures reported on Health Care Financing Administration (HCFA) billing form HCFA-1450 plus prospective payment system short-stay hospital inpatient passthrough expenditures reported on HCFA intermediary benefit payment report.

[2]Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.5

Number of facilities participating in Medicare, by type of facility: July 1, 1976-86

Type of facility	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	Percent change 1976-86
					Number							
All hospitals	6,802	6,806	6,797	6,801	6,777	6,736	6,742	6,687	6,675	6,710	6,731	-1.0
Short-stay	6,112	6,131	6,130	6,128	6,104	6,065	6,070	6,048	6,038	5,991	5,912	-3.3
Long-stay:												
Psychiatric	401	400	400	411	408	412	419	430	433	501	542	35.2
Other long-stay	289	275	267	262	265	259	253	209	204	218	277	-4.2
Skilled nursing facilities	3,928	4,002	4,749	4,963	5,052	5,258	5,408	5,760	5,952	6,725	7,148	82.0
Home health agencies	2,361	2,420	2,605	2,788	2,924	3,110	3,415	4,235	4,684	5,932	5,953	152.1
Independent laboratories	3,194	3,221	3,281	3,373	3,447	3,484	3,581	3,708	3,801	4,029	4,298	34.6

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

not having licensure laws and removed certain restrictions on HHA benefits. The large increase in the number of Medicare-certified skilled nursing facilities (SNFs) between 1984 and 1985 is believed to reflect the anticipated impact of instituting the Medicare prospective payment system (PPS) in late 1983. It was believed that the incentives embedded in PPS would reduce the lengths of hospital stays and increase Medicare-covered admissions to SNFs. Most of the Nation's hospitals participated in Medicare (6,731 hospitals in 1986).

Hospitals received the largest share of Medicare reimbursements. As shown in Table 3.6, almost all HI benefit payments in 1986 and 62 percent of total Medicare payments went for hospital inpatient services. SMI benefit payments accounted for 35 percent of total payments; 73 percent of SMI payments were for physicians' services. This distribution of payments differed slightly for aged and disabled enrollees. Disabled enrollees received a smaller proportion of HI payments and a larger proportion of SMI payments than did aged enrollees. This reflects the payments made under SMI for renal dialysis services to disabled persons with ESRD.

Information on the distribution of specific benefits for aged and disabled enrollees is presented in Tables 3.7 and 3.8, respectively. In 1986, the proportions of aged enrollees receiving each of the listed benefits was successively higher for each older age group. Among the aged, the largest proportion received physicians' services, followed by outpatient and inpatient hospital services. Only small proportions of aged enrollees received SNF or HHA benefits.

With the exception of inpatient hospital benefits, a larger proportion of aged females than males received benefits. Larger proportions of aged white enrollees received reimbursements for all services except HHA services, but enrollees of other races had higher reimbursements per person served than did white enrollees for all services. For all aged enrollees, reimbursement per person served was highest for inpatient hospital services ($6,536), followed by SNF services ($1,613), and HHA services $1,115). Reimbursements per person served for physicians' and outpatient services were $835 and $389, respectively.

For each service, the amount reimbursed per person served was higher for the disabled (Table 3.8) than for the aged (Table 3.7). The amount of outpatient reimbursement per disabled person served was much higher than the amount for the aged because of the higher proportion of ESRD patients among the disabled and the costliness of renal dialysis services.

Hospital insurance

The law governing the HI program limits coverage to a benefit period (or "spell of illness"). A benefit period begins with an enrollee's first day of hospitalization and ends when the enrollee has not been an inpatient in a hospital or SNF for at least 60 consecutive days. Although there is no limit to the number of benefit periods that an enrollee may have, there are limits on the number of days covered.

HI covers up to 90 days of services in a participating hospital during a single benefit period. After an initial deductible for each benefit period, the patient is entitled to 60 days of hospitalization with no additional cost sharing. From the 61st through the 90th day in the benefit period, the patient is responsible for coinsurance ($135 per day in 1988 and $140 in 1989) equal to one-fourth of the deductible. The Secretary of DHHS is required each year to determine the deductible amount using a formula specified by law. Reflecting increases in

Table 3.6

Medicare benefit payments, by type of enrollee, coverage, and service: Calendar year 1986

Type of coverage and service	All enrollees		Aged		Disabled	
	Amount in millions	Percent distribution	Amount in millions	Percent distribution	Amount in millions	Percent distribution
Total	$75,997	100.0	$67,152	100.0	$8,692	100.0
Hospital insurance	49,758	65.5	44,135	65.7	5,470	62.9
Inpatient hospital [1]	46,870	61.7	41,437	61.7	5,280	60.7
Skilled nursing facility [2]	604	0.8	583	0.9	21	0.3
Home health agency	2,284	3.0	2,115	3.1	169	1.9
Supplementary medical insurance	26,239	34.5	23,017	34.3	3,222	37.1
Physicians	19,213	25.3	17,279	25.7	1,934	22.3
Outpatient	5,142	6.8	4,042	6.0	1,100	12.7
Home health agency	46	0.1	46	0.1	0	0.0
Group practice plan	1,113	1.4	1,001	1.5	112	1.3
Independent laboratory [3]	725	0.9	649	1.0	76	0.8

[1] Includes $153 million for peer review organizations.
[2] Includes hospices.
[3] Includes only services billed directly by providers.

NOTE: Total, hospital insurance, and supplementary medical insurance benefit payments are actual amounts reported in Medicare trust fund reports. Distribution by type of service are preliminary estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare Cost Estimates.

Table 3.7

Persons served and reimbursements for aged Medicare enrollees, by type of coverage, type of service, and demographic characteristics: Calendar year 1986

Characteristic	Hospital insurance						Supplementary medical insurance—		
	Inpatient hospital services [1]			Skilled nursing facility services			Physicians' and other medical services		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	202.5	$6,536	$1,323	10.4	$1,613	$17	729.8	$835	$609
Age									
65-69 years	146.5	6,556	961	2.9	1,668	5	661.0	723	478
70-74 years	184.1	6,824	1,256	5.8	1,705	10	712.6	837	596
75-79 years	222.9	6,665	1,485	11.1	1,637	18	760.3	910	692
80-84 years	265.7	6,376	1,694	19.5	1,566	31	801.4	921	738
85 years or over	308.6	6,062	1,870	33.2	1,574	52	842.9	871	734
Sex									
Male	214.0	6,871	1,471	8.2	1,569	13	692.3	921	638
Female	194.7	6,287	1,224	11.9	1,633	19	754.5	782	590
Race [2]									
White	203.7	6,453	1,315	10.7	1,590	17	735.3	834	613
Other	193.4	7,393	1,430	7.5	1,938	15	681.7	859	586
Census region									
Northeast	200.8	7,149	1,436	8.3	1,737	14	766.5	843	646
North Central	210.6	6,608	1,392	12.5	1,495	19	713.4	756	539
South	218.0	5,797	1,264	8.4	1,479	12	730.9	810	592
West	178.9	7,390	1,322	15.1	1,809	27	722.8	997	720

Characteristic	Supplementary medical insurance—			Hospital insurance and/or supplementary medical insurance—		
	Outpatient services			Home health agency services		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee
Total	395.8	$389	$154	52.2	$1,115	$58
Age						
65-69 years	349.5	391	137	24.8	1,079	28
70-74 years	386.9	397	154	40.4	1,113	45
75-79 years	418.0	409	171	63.1	1,120	71
80-84 years	442.1	391	173	87.5	1,124	98
85 years or over	463.6	330	153	104.8	1,130	118
Sex						
Male	374.6	419	157	46.3	1,074	50
Female	409.7	372	152	56.1	1.138	64
Race [2]						
White	396.7	373	148	50.9	1,080	55
Other	390.0	546	213	65.4	1,375	90
Census region						
Northeast	433.3	386	167	61.6	1,065	66
North Central	429.1	375	161	45.7	915	42
South	363.6	384	140	54.3	1,307	71
West	365.9	437	160	48.8	1,086	52

[1] Hospital insurance reimbursment amounts are based on expenditures reported on Health Care Financing Administration (HCFA) billing form HCFA-1450 plus prospective payment system short-stay hospital inpatient passthrough expenditures reported on HCFA intermediary benefit payment report.

[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.8

Persons served and reimbursements for disabled Medicare enrollees, by type of coverage, type of service, and demographic characteristics: Calendar year 1986

Characteristic	Hospital insurance: Inpatient hospital services[1] — Persons served per 1,000 enrollees	Reimbursements: Per person served	Reimbursements: Per enrollee	Hospital insurance: Skilled nursing facility services — Persons served per 1,000 enrollees	Reimbursements: Per person served	Reimbursements: Per enrollee	Supplementary medical insurance—Physicians' and other medical services — Persons served per 1,000 enrollees	Reimbursements: Per person served	Reimbursements: Per enrollee
Total	215.8	$7,685	$1,658	3.4	$1,877	$6	685.2	$992	$680
Age									
Under 35 years	184.7	8,710	1,608	1.2	2,171	3	608.4	894	544
35-44 years	183.7	7,989	1,468	1.7	1,931	3	625.5	931	583
45-54 years	215.6	7,577	1,634	3.0	1,862	6	675.6	1,010	683
55-59 years	233.3	7,503	1,751	4.1	1,947	8	714.1	1,052	751
60-64 years	238.9	7,335	1,752	5.5	1,808	10	745.6	1,013	755
Sex									
Male	202.5	7,752	1,570	2.9	1,884	5	633.6	965	611
Female	255.6	7,586	1,939	4.6	1,869	9	773.0	1,030	796
Race[2]									
White	214.0	7,463	1,597	3.6	1,835	7	691.1	974	673
Other	223.6	8,538	1,909	2.9	2,116	6	661.4	1,067	706
Census region									
Northeast	214.2	8,380	1,795	2.5	1,971	5	721.0	1,007	726
North Central	223.9	8,020	1,796	4.2	1,764	7	694.6	918	637
South	234.8	6,759	1,587	2.9	1,751	5	665.1	942	627
West	197.8	9,010	1,782	5.3	2,120	11	715.4	1,215	869

Characteristic	Supplementary medical insurance—Outpatient services — Persons served per 1,000 enrollees	Reimbursements: Per person served	Reimbursements: Per enrollee	Hospital insurance and/or supplementary medical insurance—Home health agency services — Persons served per 1,000 enrollees	Reimbursements: Per person served	Reimbursements: Per enrollee
Total	440.1	$950	$418	34.2	$1,321	$45
Age						
Under 35 years	434.8	1,200	522	15.4	1,443	22
35-44 years	430.6	1,115	480	22.0	1,514	33
45-54 years	444.1	1,041	462	30.9	1,359	42
55-59 years	445.4	861	383	40.6	1,324	54
60-64 years	442.1	729	322	48.9	1,233	60
Sex						
Male	399.4	911	364	28.0	1,251	35
Female	509.4	1,001	510	45.0	1,396	63
Race[2]						
White	434.4	785	341	32.9	1,320	43
Other	466.5	1,567	731	40.2	1,328	53
Census region						
Northeast	501.7	1,063	533	40.4	1,368	55
North Central	466.8	802	374	31.7	1,111	35
South	400.6	927	371	34.9	1,448	51
West	435.9	1,083	472	32.5	1,279	42

[1] Hospital insurance reimbursment amounts are based on expenditures reported on Health Care Financing Administration (HCFA) billing form HCFA-1450 plus prospective payment system short-stay hospital inpatient passthrough expenditures reported on HCFA intermediary benefit payment report.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

hospital costs, the deductible has risen from $40 in 1966 to $540 in 1988 (increased to $560 in 1989).

HI enrollees also have a "lifetime reserve" of 60 additional hospital days, which can be used at their option when the 90 days covered in a benefit period have been exhausted. Lifetime reserve days require a coinsurance equal to one-half the deductible ($270 for each lifetime reserve day in 1988 and $280 in 1989).

In addition, the HI program pays nonparticipating hospitals for emergency services. The hospital may bill the program annually for all emergency services rendered. If this arrangement is unacceptable to the provider, the patient must pay for services received and submit a claim for reimbursement. Reimbursements are subject to a deductible and coinsurance.

Hospital services covered under HI include room and board in "semiprivate" accommodations containing from two to four beds. Private accommodations are covered if medically necessary; otherwise, the patient must pay a special charge to the hospital. Nursing services (except private-duty nursing), drugs and biologicals, and other services ordinarily furnished by a hospital to its inpatients are also covered. The HI program covers the services of interns and resident physicians in approved teaching programs. Services of other physicians, including hospital-based specialists such as radiologists, anesthesiologists,and pathologists, are covered under SMI. Hospital benefits also include reimbursement for inpatient services provided by tuberculosis hospitals and psychiatric hospitals. There is a 190-day lifetime limit for psychiatric hospitals.

Prior to the 1983 Amendments to the Social Security Act (Public Law 98-21), effective October 1, 1983, the HI program paid hospitals the "reasonable costs" of providing services to Medicare beneficiaries. Reasonable costs were determined after services had been delivered and were based on program regulations. The Medicare law and regulations specified the kinds of hospital costs allowed. Medicare, for example, does not cover private-duty nursing or costs unrelated to patient care. Once a hospital's total allowable costs were determined, Medicare apportioned the cost between Medicare patients and other patients. Medicare then paid allowable costs based on services received by Medicare patients.

The 1983 Amendments to the Social Security Act established prospective payments for Medicare inpatient hospital services, which changed the way hospitals are paid. This legislation reformed the retrospective cost-based reimbursement system for inpatient care. The new prospective payment system established one price for each diagnosis-related group (DRG). Based on diagnosis and other characteristics, the DRG system classifies patients into clinically coherent and homogeneous groups that use similar resources. Prices are established in advance for the coming year, and hospitals are paid these prices regardless of the costs they actually incur. Hospitals earn a profit when their costs fall below the prospective payment or absorb a loss when their costs are above the prospective payment. PPS is intended to provide incentives for hospitals to control costs.

Hospice use

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248) provided a new HI benefit, hospice care for the terminally ill. A hospice is a public agency or private organization primarily engaged in providing pain relief, symptom management, and supportive services to the terminally ill and their families. Congress authorized this benefit for 3 years beginning November 1, 1983. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Public Law 99-272) made hospice care a permanent benefit by removing the reference to the end date of this benefit effective April 1986, Medicare patients who qualify can receive a full range of medical and support services for their terminal condition. Hospice care is a comprehensive home-care program for the terminally ill. Medicare-covered services include physians' services, skilled nursing care, medical appliances and supplies, outpatient drugs for sympton management and pain relief, home health aide and homemaker services, medical social services, counseling, and short-term inpatient care, including inpatient respite care.

To qualify for hospice benefits, a patient must have HI coverage, and his or her doctor and the hospice medical director must certify that the patient has a terminal illness and a prognosis of 6 or fewer months to live. Patients who elect this benefit must waive the standard Medicare HI benefits for services relevant to the terminal illness. Medicare will reimburse only hospice care provided by a Medicare-certified hospice. If the patient's attending physician is not employed by the hospice, SMI pays 80 percent of allowed charges after the deductible is met for physicians' services.

From 1986 through 1987, the number of hospices approved by Medicare increased from 268 to 390, and reimbursements for hospice patients increased from $42 million to $83.9 million.

Under the hospice benefit, Medicare beneficiaries do not pay deductibles. Copayments may be collected by the hospice for only two items: a $5 maximum for each outpatient prescription for drugs and medications to manage symptoms and relieve pain and 5 percent of the cost for inpatient respite care up to the amount of the HI deductible. Respite care is a special benefit to provide a short-term inpatient stay to relieve family members or others primarily responsible for providing care to the patient at home.

Hospital use

Data on the use of and charges for inpatient hospital services are presented in Tables 3.9, 3.10, and 3.11. In 1986, there were 10.2 million Medicare inpatient hospital discharges (Table 3.9). These discharges resulted in covered charges of $59.5 billion for 87.4 million covered days of care. As derived from the table, short-stay hospital care accounted for 99 percent of all discharges and covered charges and for 97 percent of covered days of care. Aged enrolleees, who represented 91 percent of all HI enrollees, used 87 percent of all covered days of care. Discharges per 1,000 enrollees,

Table 3.9

Use of inpatient hospital services by Medicare enrollees, by type of enrollee and type of hospital: Calendar year 1986

Type of enrollee and type of hospital	Discharges		Covered days of care			Covered charges			
	Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per 1,000 enrollees
All enrollees									
All hospitals	10,171	326	87,398	8.6	2,800	$59,543	$5,854	$681	$1,907
Short-stay	10,045	322	84,639	8.4	2,711	58,543	5,828	692	1,875
Long-stay:	126	4	2,759	21.9	88	999	7,921	362	32
Psychiatric	78	2	1,659	21.3	53	487	6,250	294	16
All other	48	2	1,100	22.8	35	512	10,617	466	16
Aged									
All hospitals	8,933	316	76,449	8.6	2,705	52,118	5,834	682	1,844
Short-stay	8,861	314	74,763	8.4	2,646	51,447	5,806	688	1,821
Long-stay:	72	3	1,686	23.5	60	671	9,344	398	24
Psychiatric	32	1	740	22.8	26	249	7,678	336	9
All other	39	1	946	24.0	33	422	10,714	446	15
Disabled									
All hospitals	1,238	418	10,949	8.8	3,700	7,424	5,997	678	2,509
Short-stay	1,184	400	9,876	8.3	3,338	7,096	5,995	719	2,399
Long-stay:	54	18	1,073	19.8	363	328	6,039	306	111
Psychiatric	45	15	919	20.2	311	238	5,233	259	80
All other	9	3	154	17.4	52	90	10,187	584	30

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

covered days of care per 1,000 enrollees, and average covered charge per enrollee were lower for the aged than for the disabled.

In Tables 3.10 and 3.11, data are presented on the use of short-stay hospitals by aged and disabled enrollees, respectively. For both these groups, discharges per 1,000 enrollees increased with age. For all enrollees (aged and disabled combined), the discharge rate of males exceeded that of females, but, among the disabled, it was higher for females. For both aged and disabled persons of races other than white, the discharge rate, average length of stay, and covered charge per discharge exceeded that of white inpatients. By region, both aged and disabled enrollees in the South had the highest discharge rate but the lowest covered charge per discharge. For both aged and disabled enrollees, the West had the highest covered charge per covered day of care but the lowest average length of stay.

In Table 3.12, the number of enrollees discharged from short-stay hospitals is shown by rank order for the 20 DRGs with the largest number of discharges in 1986. The rank order of the same DRGs in 1985 and total discharges for all DRGs are also shown. The total number of discharges remained virtually unchanged from 1985 to 1986. This may represent a stabilization following a drop in the number of discharges after the institution of the Medicare prospective payment system. For instance, from 1984 to 1985, the total number of discharges dropped from 10.9 million to 10.0 milllion; a drop of about 9 percent (not shown in table).

The DRG-based payment system began in October 1983, and 2 years later most short-stay hospitals were subject to it. From the start of the Medicare program, the number of discharges from short-stay hospitals increased each year until 1983 (Table 2.10). The reasons for the decline from 1983 to 1986 are uncertain, but it may be related to greater use of outpatient care and review of hospital admissions by Medicare's utilization and quality control peer review organizations. The average length of stay among Medicare short-stay patients has fallen since the start of Medicare (Latta, 1988). The slight increase in average length of stay, from 8.6 to 8.7 days in the period 1985-86 and preliminary 1987 Medicare data may indicate that the downward trend may be at an end. Reimbursement for short-stay hospitals increased from $39.6 billion in 1985 to $41.7 billion in 1986, a 5.4 percent increase.

The rank order of 15 of the 20 leading DRGs changed from 1985 to 1986. With only slight shifts in rank order, the eight highest ranked DRGs were the same in both years.

Skilled nursing facility use

HI covers services in participating SNFs for up to 100 days in a benefit period. For the first 20 days, patients pay no coinsurance. The remaining 80 days require coinsurance equal to one-eighth of the inpatient deductible ($67.50 in 1988 and $70 in 1989). A beneficiary is eligible for SNF benefits only after hospitalization for at least 3 consecutive days and only if the transfer to an SNF occurs within 30 days after a hospital discharge.

Data on the use of SNFs by aged and disabled enrollees in 1986 are reported in Table 3.13. Information on persons served and reimbursements are shown by age, sex, race, and region. Overall, a much higher proportion of aged than disabled enrollees received SNF benefits—10.4 persons served per 1,000 aged enrollees compared with 3.4 per 1,000 disabled enrollees. Reimbursements per person served, however, were 16 percent higher for the disabled than for the aged. For both aged and disabled enrollees, the number of persons served per 1,000 enrollees was successively

Table 3.10

Use of short-stay hospital inpatient services by aged Medicare enrollees, by demographic characteristics: Calendar year 1986

Characteristic	Aged hospital insurance enrollees in thousands [1]	Discharges		Covered days of care			Covered charges			
		Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per enrollee
Total	28,257	8,861	314	74,763	8.4	2,646	$51,447	$5,806	$688	$1,821
Age										
65-66 years	3,881	797	205	5,938	7.5	1,530	4,559	5,722	768	1,175
67-68 years	3,477	801	230	6,206	7.7	1,785	4,680	5,842	754	1,346
69-70 years	3,261	838	257	6,665	8.0	2,044	4,942	5,897	741	1,516
71-72 years	3,067	868	283	7,097	8.2	2,314	5,147	5,929	725	1,678
73-74 years	2,738	847	309	7,100	8.4	2,593	5,083	6,001	716	1,856
75-79 years	5,431	1,905	351	16,450	8.6	3,029	11,257	5,908	684	2,073
80-84 years	3,479	1,442	415	12,876	8.9	3,701	8,277	5,739	643	2,379
85 years or over	2,924	1,362	466	12,431	9.1	4,252	7,503	5,507	604	2,566
Sex										
Male	11,378	3,847	338	31,477	8.2	2,766	23,350	6,070	742	2,052
Female	16,879	5,014	297	43,286	8.6	2,565	28,098	5,604	649	1,665
Race [2]										
White	24,902	7,853	315	65,403	8.3	2,626	44,928	5,721	687	1,804
All other	2,515	1,008	401	9,360	9.3	3,722	6,520	6,468	697	2,593
Census region										
Northeast	6,418	1,978	308	19,804	10.0	3,086	12,202	6,169	616	1,901
North Central	7,179	2,324	324	19,233	8.3	2,679	13,033	5,609	678	1,816
South	9,195	3,127	340	25,449	8.1	2,768	16,872	5,396	663	1,835
West	4,896	1,368	279	9,764	7.1	1,994	9,148	6,686	937	1,868

[1] As of July 1, 1986.

[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.11

Use of short-stay hospital inpatient services by disabled Medicare enrollees, by demographic characteristics: Calendar year 1986

Characteristic	Disabled hospital insurance enrollees in thousands [1]	Discharges		Covered days of care			Covered charges			
		Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per enrollee
Total	2,959	1,184	400	9,876	8.3	3,338	$7,096	$5,995	$719	$2,399
Age										
Under 35 years	433	137	317	1,220	8.9	2,817	788	5,746	646	1,819
35-44 years	498	160	322	1,371	8.6	2,755	915	5,720	668	1,839
45-54 years	613	236	385	1,908	8.1	3,113	1,358	5,755	712	2,215
55-59 years	552	230	417	1,875	8.2	3,396	1,367	5,946	729	2,477
60-64 years	863	421	488	3,503	8.3	4,060	2,668	6,342	762	3,092
Sex										
Male	1,881	697	371	5,708	8.2	3,035	4,204	6,028	737	2,236
Female	1,078	486	451	4,169	8.6	3,868	2,892	5,947	694	2,683
Race [2]										
White	2,355	929	394	7,634	8.2	3,241	5,419	5,833	710	2,301
All other	548	255	465	2,243	8.8	4,094	1,677	6,584	748	3,061
Census region										
Northeast	605	237	392	2,290	9.6	3,784	1,506	6,339	657	2,488
North Central	693	287	414	2,453	8.6	3,542	1,725	6,010	703	2,490
South	1,078	469	435	3,725	7.9	3,457	2,568	5,479	689	2,383
West	475	178	376	1,313	7.4	2,767	1,258	7,048	958	2,650

[1] As of July 1, 1986.

[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.12

Short-stay hospital discharge, by rank order of the 20 diagnosis-related groups with the most discharges in 1986: Calendar years 1985 and 1986

Diagnosis-related group number and description	1986			1985		
	Discharges [1]		Average length of stay in days	Discharges [1]		Average length of stay in days
	Number in thousands	Rank order		Number in thousands	Rank order	
All diagnosis-related groups	10,044.6	NA	8.7	10,027.0	NA	8.6
20 leading diagnosis-related groups	4,347.7	NA	8.7	4,211.4	NA	8.6
127 Heart failure and shock	511.5	1	8.1	498.3	1	8.2
140 Angina pectoris	371.1	2	5.0	348.9	2	5.2
089 Simple pneumonia and pleurisy, age greater than 69 and comorbidity or complications	368.9	3	9.0	347.3	3	9.0
014 Specific cerebrovascular disorders except transient ischemic attack	320.9	4	11.0	312.3	5	11.3
182 Esophagitis, gastroenteritis, and miscellaneous digestive disorders, age greater than 69 and comorbidity or complications	301.2	5	6.0	313.1	4	5.9
296 Nutritional and miscellaneous metabolic disorders, age greater than 69 and comorbidity or complications	219.8	6	7.7	208.1	7	7.7
138 Cardiac arrhythmia and conduction disorders, age greater than 69 and comorbidity or complications	219.8	7	5.9	209.6	6	6.0
096 Bronchitis and asthma, age greater than 69 and comorbidity or complications	211.9	8	7.2	186.9	8	7.0
209 Major joint procedures	177.9	9	13.7	164.8	12	14.2
336 Transurethral prostatectomy, age greater than 69 and comorbidity or complications	172.0	10	6.6	160.9	13	7.1
320 Kidney and urinary tract infections, age greater than 69 and comorbidity or complications	161.7	11	8.3	140.4	17	8.0
015 Transient ischemic attacks	161.7	12	5.6	168.0	11	5.7
088 Chronic obstructive pulmonary disease	161.6	13	8.3	172.5	9	8.2
174 Gastrointestinal hemorrhage, age greater than 69 and comorbidity or complications	156.5	14	6.9	150.9	14	6.9
243 Medical back problems	153.1	15	7.0	169.2	10	7.3
430 Psychoses	147.6	16	16.3	130.9	18	16.4
468 Unrelated operating room procedure	142.9	17	15.6	152.0	15	15.4
122 Circulatory disorders with acute myocardial infarction without cardiovascular complications, discharged alive	134.2	18	8.5	142.8	16	9.3
121 Circulatory disorders with acute myocardial infarction and cardiovascular complications, discharged alive	127.0	19	11.2	117.5	21	11.5
148 Major small and large bowel procedures, age greater than 69 and/or complication or comorbidity	126.6	20	16.7	117.0	22	16.5

[1] Discharge figures for 1985 and 1986 differ from those in Table 2.10 because they were derived from different data sources and different processing cutoff dates.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Office of Research.

higher for older age groups, higher proportions of females than males received SNF benefits, and rates per 1,000 enrollees were much higher among white persons than among all other persons. Reimbursements per person served were higher for all other persons than for white persons. The number of persons served per 1,000 aged and disabled enrollees was lowest in the Northeast and highest in the West. Reimbursements per person served were lowest in the South and North Central regions and highest in the West for both aged and disabled enrollees.

Table 3.13

Use of skilled nursing facilities by aged and disabled Medicare enrollees, by demographic characteristics: Calendar year 1986

Type of enrollee and characteristic	Hospital insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Aged						
Total	28,257.0	294.3	10.4	$474.5	$1,612	$16.79
Age:						
65-69 years	9,012.6	26.0	2.9	43.4	1,668	4.82
70-74 years	7,411.3	43.3	5.8	73.9	1,704	9.97
75-79 years	5,430.9	60.0	11.1	98.3	1,636	18.10
80-84 years	3,478.7	67.8	19.5	106.1	1,566	30.50
85 years or over	2,923.5	97.1	33.2	152.8	1,574	52.27
Sex:						
Male	11,378.2	93.6	8.2	146.8	1,568	12.90
Female	16,878.8	200.7	11.9	327.7	1,633	19.41
Race:[2]						
White	24,902.0	267.5	10.7	425.3	1,589	17.08
Other	2,514.7	18.8	7.5	36.5	1,937	14.51
Census region:						
Northeast	6,417.6	53.1	8.3	92.3	1,736	14.38
North Central	7,178.9	89.9	12.5	134.3	1,494	18.71
South	9,195.3	77.0	8.4	113.9	1,479	12.39
West	4,896.3	73.8	15.1	133.5	1,808	27.27
Disabled						
Total	2,958.5	10.1	3.4	19.0	1,877	6.42
Age:						
Under 35 years	432.9	0.5	1.2	1.1	2,171	2.54
35-44 years	497.6	0.8	1.7	1.6	1,930	3.22
45-54 years	613.0	1.8	3.0	3.4	1,862	5.55
55-59 years	552.1	2.3	4.1	4.4	1,947	7.97
60-64 years	862.9	4.7	5.5	8.5	1,808	9.85
Sex:						
Male	1,880.7	5.5	2.9	10.3	1,884	5.48
Female	1,077.9	4.6	4.3	8.7	1,869	8.07
Race:[2]						
White	2,355.1	8.4	3.6	15.4	1,835	6.54
Other	547.8	1.6	2.9	3.3	2,116	6.02
Census region:						
Northeast	605.1	1.5	2.5	3.0	1,971	4.96
North Central	692.7	2.9	4.2	5.1	1,764	7.36
South	1,077.7	3.2	2.9	5.5	1,751	5.10
West	474.7	2.5	5.3	5.3	2,120	11.16

[1] As of July 1, 1986.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Home health agency use

The third type of benefit covered by HI is HHA services for persons under the care of a physician, confined to the home, and needing part-time or intermittent skilled nursing care or therapy. Covered services include skilled nursing care; physical, occupational, or speech therapy; part-time or intermittent services of a home health aide; medical supplies (other than drugs and biologicals); the use of medical appliances; and, in certain cases, services of an intern or resident. The services must be furnished by an approved HHA.

In Table 3.14, data are presented on the use of HHA services in 1986. The number of HHA visits per 1,000 enrollees was 25 percent greater for the aged than for the disabled. Because reimbursements per visit were similar for both groups, reimbursements per enrollee were 25 percent higher for the aged, $58, than for the disabled, $46. Females had more visits and reimbursements per enrollee than did males. White persons had lower visits and reimbursements per enrollee than did persons of other races.

Supplementary medical insurance

The SMI program covers physicians' services, including visits to the home, office, hospital, and other institutions. The program also pays for other services and supplies, such as drugs and biologicals that cannot be self-administered, if they are furnished as part of a physician's professional services; diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests; X-ray, radium, and radioactive isotope therapy; splints, casts, and other devices used for reduction for fractures and dislocations; purchase or rental of durable medical equipment; ambulance services; and prosthetic devices that replace all or part of a body organ. In addition, SMI pays for outpatient services received in hospitals, rural health centers, community health centers, and renal dialysis centers as well as outpatient rehabilitation, speech therapy, and physical therapy services. The 1972 Amendments to the Social Security Act (Public Law 92-603), effective July 1, 1973, provide for coverage of services of physical therapists in independent practice furnished in their office or the patient's home if the services are under a physician's plan. The reimbursement limit for these services was increased from $100 to $500 by ORA 1980. Lastly, limited chiropractic and optometric services are also covered.

During each calendar year, enrollees must exceed the SMI deductible to receive reimbursable services. From 1973 through 1981, the annual deductible was $60 of reasonable charges; beginning in 1982, it was increased to $75.

After the deductible is met, SMI pays 80 percent of the allowed (reasonable) charges for covered physicians' services and most other medical services. The allowed charge is determined for each specific service and is the lowest of:

- The physician's actual charge for the service.
- The physician's customary charge for the service (the physician's 50th percentile charge level for the specific type of service).
- The prevailing charge, which is set at the 75th percentile of the customary charges for the service charged by physicians in an area defined by the carrier.

Increases in the prevailing charge are limited by the Medicare Economic Index (mandated by the 1972 Amendments to the Social Security Act). The percent increase in the Index is the maximum allowable increase in the prevailing charge for a physician's service. This percentage is based on the weighted averages of changes in general earnings levels, changes in expenses incurred by physicians in office practice, and general inflation.

Table 3.14

Visits, charges, and reimbursements for Medicare-covered home health agency services, by type of enrollee, sex, and race: Calendar year 1986

Type of enrollee, sex, and race	Visits		Charges			Reimbursements		
	Number in millions	Per 1,000 enrollees	Amount in millions	Amount in millions for visits [1]	Amount per visit [1]	Amount in millions	Per visit	Per enrollee
Total	38.4	1,208	$2,190.2	$2,102.3	$54.80	$1,795.8	$46.82	$56.56
Type of enrollee								
Aged	35.5	1,231	2,020.6	1,943.4	54.82	1,658.9	46.79	57.62
Disabled	2.9	982	169.6	158.8	54.67	136.9	47.14	46.28
Sex								
Male	13.5	1,011	780.8	745.2	55.00	637.3	47.04	47.54
Female	24.8	1,353	1,409.4	1,357.1	54.70	1,158.5	46.69	63.15
Race [2]								
White	31.8	1,154	1,805.0	1,736.3	54.51	1,483.9	46.59	53.78
Other	5.5	1,693	325.5	308.7	56.53	263.1	48.18	81.56

[1] Excludes durable medical equipment and supplies, except for drugs and biologicals, furnished by home health agencies.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.15

Average reasonable charge or cost and reimbursement per enrollee for supplementary medical insurance (SMI), by type of service and type of enrollee: Years ending June 30, 1974-86

Type of enrollee and year	Average enrollment in thousands	All services		Physicians' services [1]		Outpatient services		Home health agency services		Health care prepayment plan services		Independent laboratory services	
		Reasonable cost or charge	Reimbursement	Reasonable cost or charge	Reimbursement	Reasonable cost or charge	Reimbursement	Reasonable cost or charge	Reimbursement	Reasonable cost or charge	Reimbursement	Reasonable cost or charge	Reimbursement
Aged						Amount							
1974	20,988	$204.19	$134.38	$178.33	$117.48	$17.75	$11.32	$2.54	$2.03	$3.69	$2.35	$1.88	$1.20
1975	21,504	236.59	160.26	201.27	136.28	23.51	15.45	4.66	3.83	4.66	3.06	2.49	1.64
1976	22,089	272.01	188.60	225.46	156.27	31.62	21.26	6.18	5.19	5.74	3.86	3.01	2.02
1977	22,604	313.23	221.38	253.83	179.30	41.77	28.68	7.60	6.52	6.43	4.41	3.60	2.47
1978	23,133	354.22	254.20	288.60	207.05	47.85	33.38	7.82	6.82	5.77	4.03	4.18	2.92
1979	23,693	398.81	289.55	322.19	233.99	57.28	40.51	7.76	6.86	6.89	4.87	4.69	3.32
1980	24,287	465.78	343.00	376.39	277.24	65.50	47.08	8.44	7.58	9.80	7.04	5.65	4.06
1981	24,827	545.28	407.42	438.85	328.14	77.72	56.72	8.81	8.04	12.51	9.13	7.39	5.39
1982	25,363	629.09	465.40	513.50	381.02	91.12	66.41	0.52	0.52	15.07	10.98	8.88	6.47
1983	25,873	753.23	558.26	613.18	454.90	110.92	81.70	0.77	0.77	18.40	13.55	9.96	7.34
1984	26,433	855.86	638.57	685.14	511.35	134.88	100.31	0.99	0.99	22.56	16.78	12.29	9.14
1985	26,914	922.21	701.18	707.94	537.99	172.52	128.07	1.05	1.05	25.74	19.11	14.96	14.96
1986	27,453	1,028.12	790.24	785.09	603.21	179.47	133.88	1.17	1.17	40.97	30.56	21.42	21.42
Disabled [2]													
1974	1,638	171.05	116.65	143.27	97.59	20.99	13.88	4.17	3.45	1.63	1.08	0.99	0.65
1975	1,816	212.15	149.48	178.49	125.69	25.26	17.32	4.17	3.57	2.69	1.84	1.54	1.06
1976	2,018	250.25	178.83	207.86	148.38	31.25	21.70	5.90	5.12	3.13	2.17	2.11	1.46
1977	2,231	303.47	220.43	240.43	174.81	51.44	36.44	5.41	4.79	3.37	2.39	2.82	2.00
1978	2,423	349.56	256.25	276.50	202.91	59.80	42.76	6.19	5.53	3.43	2.45	3.64	2.60
1979	2,563	406.69	301.57	324.16	240.74	69.68	50.49	5.66	5.13	2.81	2.04	4.38	3.17
1980	2,641	484.35	363.44	383.99	288.53	82.69	60.72	6.63	6.09	5.82	4.27	5.22	3.83
1981	2,687	568.19	430.92	448.53	340.65	98.63	73.21	7.78	7.22	6.92	5.14	6.33	4.70
1982	2,685	687.51	517.42	523.38	395.48	147.81	109.82	(3)	(3)	8.43	6.26	7.89	5.86
1983	2,628	839.84	632.79	643.57	485.68	176.45	132.26	(3)	(3)	10.09	7.56	9.73	7.29
1984	2,593	895.85	675.38	700.15	528.24	172.88	129.98	(3)	(3)	10.97	8.25	11.85	8.91
1985	2,593	931.11	712.80	718.41	550.16	187.41	140.29	(3)	(3)	11.70	8.76	13.59	13.59
1986	2,629	993.28	766.09	758.09	585.04	200.54	150.33	(3)	(3)	15.69	11.76	18.96	18.96

[1] Figures vary from those in Tables 3.16 and 3.17, as explained in the Note. Also, data in Tables 3.16 and 3.17 are for physicians' and other medical services; these data are for physicians' services only.

[2] Excludes enrollees with end stage renal disease only.

[3] The Omnibus Budget Reconcilation Act of 1980 removed the 3-day hospital stay as a precondition for home health agency benefits under hospital insurance (HI). The act provides that services previously paid for by HI and SMI will now be paid for by HI.

NOTE: Figures vary from those in other tables in this report. These figures are actuarial estimates from a 0.1-percent sample of all aged enrollees and a 1.0-percent sample of all disabled enrollees. Reimbursements are estimated by subtracting deductibles and coinsurance amounts from reasonable costs or charges for each enrollee. Charges that exceed amounts the program deems reasonable are excluded.

SOURCE: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1988 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.* Washington. U.S. Government Printing Office, May 5, 1988.

Physicians make an annual choice to accept or reject assignment. Accepting assignment means that a participating physician submits the bill to the carrier and agrees to accept 80 percent of the reasonable charge. The patient is responsible for the deductible and the remaining 20 percent of the reasonable charge. The nonparticipating physician does not accept assignment and bills the patient. The patient is responsible for the physician's total charge. The patient submits the bill to the carrier. The carrier pays the patient 80 percent of the reasonable charge after the deductible is met.

The Deficit Reduction Act (DEFRA) of 1984 (Public Law 98-369) was an effort to contain the rate of growth in Medicare physician charges. For the 15 months beginning July 1, 1984, DEFRA froze Medicare customary and prevailing charges for all physicians and actual charges for nonparticipating physicians at the levels that were in effect for the 12 months ending June 30, 1984. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Public Law 99-272) extended the freeze on customary and prevailing charges and on nonparticipating physicians' actual charges. Subsequently, OBRA 1986 (Public Law 99-509) and its amendment in OBRA 1987 (Public Law 100-203) established two prevailing charge levels, one for participating physicians and one for nonparticipating physicians for services furnished starting January 1, 1987. Prevailing charges were set 4 percent higher for participating physicians than for nonparticipating physicians. The legislation also set limits on actual charges of nonparticipating physicians effective January 1, 1987.

Physicians who serve Medicare patients can choose to be participating or nonparticipating physicians. Participating physicians voluntarily sign an agreement to accept assignment for all services provided to Medicare patients for a year. Nonparticipating physicians may accept assignment on a claim-by-claim basis. Medicare furnishes incentives for physician participation, including directories of participating physicians, dissemination of the names of participating physicians by toll-free telephone lines, and electronic receipt of claims by carriers. OBRA 1986 provided additional incentives to carriers to encourage beneficiaries to use participating physicians and to reward carriers who recruit participating physicians.

What effect did DEFRA 1984 and subsequent legislation have on assignment rates? Assignment rates are based on total charges of assigned claims as a percent of total charges submitted by physicians. The assignment rate rose from 56.3 percent in fiscal year 1983 to 69.5 in fiscal year 1986, in part, because of incentives to participating physicians provided by DEFRA and later legislation. This was the most rapid increase in assignment rates since HCFA began collecting such charge data. The assignment rate includes State buy-in claims for which assignment is mandatory. It also includes assigned charges of both participating and nonparticipating physicians.

Outpatient treatment for mental illness is also subject to the deductible and coinsurance. Prior to 1988, maximum annual Medicare payments for outpatient treatment of mental disorders by physicians were limited to $250. OBRA 1987 raised the limit to $450 beginning in calendar year 1988. Beginning in calendar year 1989, brief office visits for the sole purpose of prescribing or monitoring prescription drugs used in the treatment of mental disorders were excluded from the computation of the limit.

In Table 3.15, SMI data on average reasonable charges and reimbursements per enrollee are reported. Data are presented for the period 1974-86 by type of enrollee. Reimbursements were estimated by subtracting deductible and coinsurance amounts from reasonable costs or charges for each enrollee. Charges that exceeded reasonable charges were excluded.

In 1974, the program reimbursed only 66 percent of reasonable costs or charges to aged enrollees. (Reimbursements are 80 percent of reasonable charges after subtracting the SMI deductible.) Reasonable costs or charges for all services were $204.19 per aged enrollee in 1974, and reimbursements were $134.38 per enrollee. As derived from Table 3.15, reasonable charges per aged enrollee rose 404 percent from 1974 to 1986; the SMI deductible rose only 25 percent in the same period (from $60 to $75 a year). Because the deductible became smaller in relation to reasonable charges, reimbursements as a percent of reasonable charges increased. Thus, by 1986, reimbursements to the aged increased to 77 percent of reasonable charges. In 1974 Medicare reimbursed 68 percent of reasonable costs or charges to the disabled. By 1986, the comparable figure for the disabled had also risen to 77 percent. Physicians' services made up the major share of SMI reimbursements in 1986, comprising 77 percent of reimbursement for both the aged and the disabled. By 1982, HHA services were reimbursed at 100 percent of reasonable costs. Although most HHA services were covered by the HI program, aged enrollees covered only by SMI used HHA services under the SMI program.

In Tables 3.16 and 3.17, data are provided on physicians' and other medical services used in 1986 by aged and disabled enrollees, respectively. The number of persons served per 1,000 enrollees was 7 percent higher for aged enrollees (730) than for disabled enrollees (685). However, reimbursement per person served was 19 percent higher for disabled enrollees ($992 versus $835). As a result, reimbursement per enrollee was 12 percent higher for disabled than aged enrollees.

For physicians' and other medical services, the number of persons served per 1,000 enrollees increased with age among both aged and disabled enrollees. Reimbursements for both aged and disabled persons served generally increased with age. Proportionately more females than males received benefits in both enrollee groups, although (as derived from the tables) reimbursement per person served was 18 percent higher for aged males than for aged females. Among the disabled, average reimbursements per person served were 7 percent higher for females. Among both the aged and the disabled, the number of persons served per 1,000 enrollees was higher for white persons than for all other persons, but reimbursement per person served was lower for white persons. Data by region show that aged and disabled enrollees living in the West had the highest amount reimbursed per person served.

Table 3.16

Use of physicians' and other medical services by aged Medicare enrollees under supplementary medical insurance (SMI), by demographic characteristics: Calendar year 1986

Characteristic	Aged SMI enrollees in thousands [1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	27,862.7	20,334.8	729.8	$16,972.3	$834.64	$609.14
Age						
65-69 years	8,748.5	5,782.7	661.0	4,179.2	722.71	477.71
70-74 years	7,399.5	5,273.1	712.6	4,412.8	836.85	596.37
75-79 years	5,456.4	4,148.3	760.3	3,774.0	909.77	691.67
80-84 years	3,480.9	2,789.7	801.4	2,568.4	920.65	737.86
85 years or over	2,777.4	2,341.0	842.9	2,037.9	870.54	733.74
Sex						
Male	11,058.1	7,655.8	692.3	7,051.9	921.11	637.71
Female	16,804.6	12,679.0	754.5	9,920.4	782.43	590.34
Race [2]						
White	24,498.1	18,013.7	735.3	15,022.7	833.96	613.22
Other	2,527.7	1,723.3	681.7	1,480.0	858.82	585.51
Census region						
Northeast	6,376.2	4,887.1	766.5	4,119.5	842.93	646.08
North Central	7,121.6	5,080.7	713.4	3,842.1	756.20	539.50
South	9,199.4	6,724.1	730.9	5,447.7	810.17	592.18
West	4,890.7	3,535.1	722.8	3,523.0	996.57	720.35

[1] As of July 1, 1986.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.17

Use of physicians' and other medical services by disabled Medicare enrollees under supplementary medical insurance (SMI), by demographic characteristics: Calendar year 1986

Characteristic	Disabled SMI enrollees in thousands [1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	2,727.0	1,868.6	685.2	$1,853.9	$992.12	$679.83
Age						
Under 35 years	400.5	243.7	608.4	217.8	893.66	543.82
35-44 years	452.8	283.3	625.5	263.8	931.47	582.60
45-54 years	561.1	379.0	675.6	383.0	1,010.43	682.59
55-59 years	508.4	363.1	714.1	382.0	1,052.03	751.38
60-64 years	804.2	599.5	745.6	607.3	1,012.94	755.16
Sex						
Male	1,717.4	1,088.2	633.6	1,049.8	964.66	611.27
Female	1,009.6	780.4	773.0	804.1	1,030.42	796.45
Race [2]						
White	2,166.7	1,497.5	691.1	1,458.6	974.06	673.19
Other	508.2	336.1	661.4	358.7	1,067.10	705.83
Census region						
Northeast	561.8	405.1	721.0	408.1	1,007.39	726.42
North Central	645.2	448.2	694.6	411.3	917.61	637.48
South	1,018.6	677.5	665.1	638.4	942.29	626.74
West	446.5	319.4	715.4	388.1	1,215.02	869.21

[1] As of July 1, 1986.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.18

Physicians' and suppliers' charges and Medicare reimbursements for aged and disabled enrollees combined, by census region: Calendar year 1986

Census region	Charges		Percent reduction in total charges	Reimbursements	
	Total	Reasonable		Amount in in millions	As percent of total charges
	Amount in millions				
All areas	$35,154	$25,125	28.5	$18,826	53.6
United States	35,017	25,032	28.5	18,778	53.6
Northeast	8,985	6,143	31.6	4,528	50.4
North Central	8,033	5,842	27.3	4,253	53.0
South	11,017	7,902	28.3	6,086	55.2
West	6,982	5,146	26.3	3,911	56.0

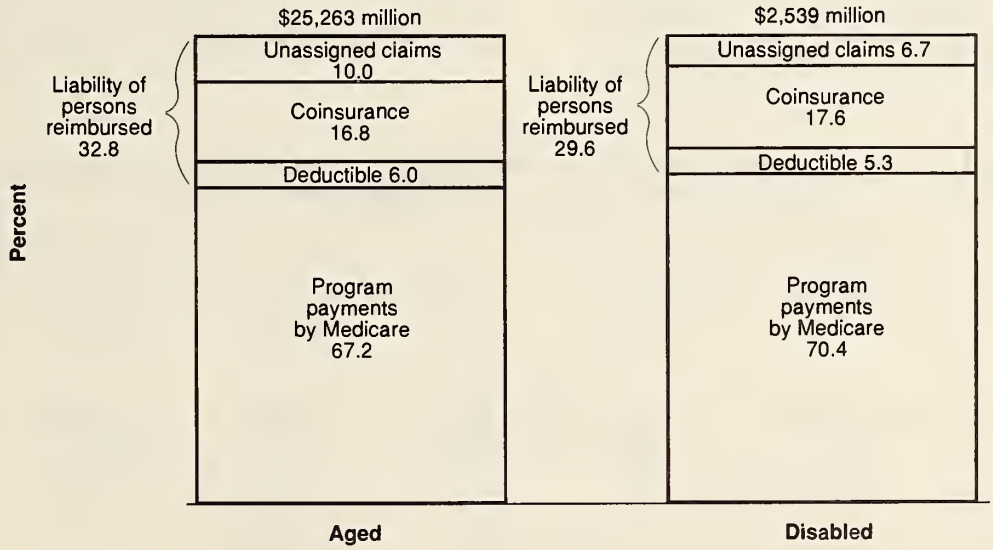
SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Office of Research.

Data on total physicians' and suppliers' charges, reasonable charges as determined by carriers, and amounts reimbursed by Medicare in 1986 are shown in Table 3.18 for aged and disabled enrollees combined. Medicare carriers reduced physicians' total charges by 28.5 percent. The percent reduction was highest in the Northeast and lowest in the West. Medicare reimbursed 53.6 percent of physicians' submitted charges after carriers made reasonable charge reductions and subtracted deductible and coinsurance amounts. The proportion of reimbursements for physicians' charges differed only slightly by region.

The distribution of the amounts due to physicians (total charges less the reduction amount on assigned claims) by the amount paid by Medicare and the type and amount of beneficiary liability is shown in Figure 3.1. In 1986, among aged persons served, Medicare paid 67.2 percent of total physicians' charges due. The remainder, 32.8 percent, comprised the coinsurance (16.8 percent), the reduction on unassigned claims (10.0 percent), and the deductible (6.0 percent). The proportion reimbursed by Medicare for disabled persons served was 70.4 percent, somewhat higher than that for the aged.

Figure 3.1

Percent distribution of Medicare program payments and beneficiary liability for physicians' services, by type of enrollee: Calendar year 1986



SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Data from the Division of Information Analysis.

Table 3.19

Use of outpatient services by aged Medicare enrollees under supplementary medical insurance (SMI), by age, sex, and race: Calendar year 1986

Age, sex, and race	Aged SMI enrollees in thousands [1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	27,862.7	11,028.1	395.8	$4,292.9	$389.27	$154.07
Age						
65-69 years	8,748.5	3,057.8	349.5	1,196.6	391.32	136.77
70-74 years	7,399.5	2,862.6	386.9	1,137.6	397.38	153.73
75-79 years	5,456.4	2,281.0	418.0	931.9	408.56	170.79
80-84 years	3,480.9	1,539.0	442.1	602.3	391.35	173.02
85 years or over	2,777.4	1,287.6	463.6	424.6	329.72	152.86
Sex						
Male	11,058.1	4,142.9	374.6	1,734.4	418.66	156.84
Female	16,804.6	6,885.2	409.7	2,558.5	371.59	152.24
Race [2]						
White	24,498.1	9,718.4	396.7	3,622.0	372.70	147.84
All other	2,527.7	985.8	390.0	538.3	546.01	212.94

[1] As of July 1, 1986.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Data on outpatient services provided to aged and disabled enrollees under SMI are presented in Tables 3.19 and 3.20, respectively. In 1986, reimbursements totaled $4.3 billion for aged enrollees and $1.1 billion for disabled enrollees. As derived from the tables, the disabled accounted for 21 percent of total reimbursements for outpatient services, although they represented 9 percent of all enrollees. The number of persons served per 1,000 enrollees was higher for disabled than for aged enrollees. Reimbursement per person served was 2.4 times as great for the disabled ($950) as for the aged ($389). By age, the highest amount reimbursed per person served was $1,200 for disabled enrollees under age 35. This large reimbursement reflects the relatively high proportion of disabled persons with ESRD in this age group. Renal dialysis services required by persons with ESRD are covered by Medicare as an outpatient benefit.

For outpatient services, the number of persons served per 1,000 aged enrollees was 9 percent greater for females, but males had a 13 percent greater reimbursement per person served (derived from Table 3.19). As a result, reimbursements per enrollee were 3 percent greater among males. Aged white persons had a user rate 2 percent higher than the rate

Table 3.20

Use of outpatient services by disabled Medicare enrollees under supplementary medical insurance (SMI), by age, sex, and race: Calendar year 1986

Age, sex, and race	Disabled SMI enrollees in thousands [1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	2,727.0	1,200.2	440.1	$1,139.8	$949.69	$417.97
Age						
Under 35 years	400.5	174.1	434.8	208.9	1,199.69	521.10
35-44 years	452.8	195.0	430.6	217.4	1,114.71	480.12
45-54 year	561.1	249.2	444.1	259.3	1,040.77	462.13
55-69 years	508.4	226.4	445.4	194.9	860.87	383.34
60-64 years	804.2	355.5	442.1	259.3	729.47	322.43
Sex						
Male	1,717.4	685.9	399.4	625.1	911.36	363.98
Female	1,009.6	514.3	509.4	514.7	1,000.81	509.81
Race [2]						
White	2,166.7	941.3	434.4	738.9	785.03	341.02
All other	508.2	237.1	466.5	371.6	1,567.39	731.21

[1] As of July 1, 1986.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

for all other persons but persons other than white had a 47 percent higher reimbursement per person served, resulting in a 44 percent higher reimbursement per enrollee for persons of other races. Among aged persons of other races, black persons have a significantly greater proportion of enrollees with ESRD than do white persons. The costs of dialysis services for this group would increase the amount reimbursed per person served. Another factor that may also contribute to this difference in the amounts reimbursed per person served is the more frequent use made by black persons of hospital outpatient clinics and emergency rooms for medical care (Health Care Financing Administration, 1990).

Data on outpatient service use among disabled enrollees show that higher proportions of females received reimbursement for services and also higher reimbursements per person served than did males. The combined effect was a 40 percent higher reimbursement per enrollee for disabled females than for males. Differences were even more striking by race. A smaller proportion of white persons than all other persons used outpatient services, and white persons also received much lower reimbursements per person served. This resulted in an average reimbursement per enrollee for all persons other than white that was 114 percent higher than that for white persons. The impact of the costs of renal dialysis services for black persons with ESRD is even greater among the disabled than among the aged. The difference in ESRD prevalence rates by race is wider among the age groups under 65 years of age (Health Care Financing Administration, 1990).

Data on covered hospital outpatient charges and reimbursements in 1986 for aged and disabled enrollees (including those with ESRD) are shown in Table 3.21 by census region. The proportions of charges reimbursed were 58.4 percent for aged enrollees and 67.5 percent for disabled enrollees. The amount reimbursed per disabled enrollee was triple the amount reimbursed per aged enrollee, primarily because most ESRD patients are included among the disabled. Among the aged, reimbursements per enrollee were lowest in the South and highest in the North Central region. Among disabled enrollees, the North Central region had the lowest reimbursement per enrollee. The percent of charges reimbursed was highest in the North Central region and lowest in the Northeast.

Financing

HI is financed primarily through a tax on a portion of current employment earnings covered by the Social Security Act. Other sources of income for the program (shown in Table 3.22) include proceeds from the railroad retirement system, income to the trust fund appropriated from general revenues to reimburse the program for costs of transitionally insured persons, and interest earned by the fund. These monies are earmarked for the HI trust fund to pay benefits and administrative expenses.

In 1986, payroll taxes accounted for 92 percent of the HI trust fund's total income. In the 1960s, the payroll tax share fluctuated from a high of 96 percent in 1966 to a low of 78 percent in 1968. Since 1968, benefit payments have accounted for 97 percent or more of all HI disbursements.

The Federal SMI trust funds (Table 3.23) come from premiums paid by or on behalf of SMI enrollees, contributions of the Federal Government from the general fund of the Treasury, and interest from investments of the fund. When Medicare began, the monthly SMI premium was $3. As of January 1, 1988, the premium had risen to $24.80 per month. Until 1973, premiums were set to finance one-half of the benefit and administrative costs of the SMI program plus a contingency amount. General revenues financed the other half. The 1972 Amendments to the Social Security Act altered that arrangement. Beginning July 1973, monthly premiums can be raised only if monthly social security cash benefits are increased. Furthermore, premiums are permitted to rise no more than the percentage increase in cash benefits. The 1983 Amendments to the Social Security Act changed the premium adjustment period from a 12-month period ending June 30 to one ending December 31. Therefore, since January 1, 1984 premium adjustments have been made on a calendar-year basis. Legislation set the Part B premium at 25 percent of the expected average cost for aged enrollees for calendar years 1984 through 1989.

Table 3.21

Hospital outpatient covered charges and Medicare reimbursements, by type of enrollee and census region: Calendar year 1986

	Covered charges in millions		Reimbursements					
			Amount in millions		Per enrollee		As percent of covered charges	
Census region	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled
All areas	$6,529.3	$1,586.7	$3,810.0	$1,071.6	$136.74	$410.44	58.4	67.5
United States	6,507.3	1,571.0	3,797.2	1,060.4	137.64	414.44	58.4	67.5
Northeast	1,632.9	394.8	914.1	264.5	143.36	492.77	56.0	67.0
North Central	1,691.8	329.0	1,060.2	226.3	148.87	365.19	62.7	68.8
South	1,948.1	545.3	1,118.3	365.2	121.57	373.88	57.4	67.0
West	1,234.6	301.9	704.6	204.4	144.07	480.49	57.1	67.7

NOTE: Includes enrollees with end stage renal disease.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.22

Operations of the Medicare hospital insurance trust fund: Calendar years 1966-86

Year	Income							Disbursements			Trust fund	
	Total income	Payroll taxes	Transfers from railroad retirement account	Reimbursement for transitionally insured persons	Premiums from voluntary enrollees	Reimbursement for military wage credits	Interest on investments and other income[1]	Total disbursements	Benefit payments[2]	Administrative expenses[3]	Net change	Yearend balance
	Amount in millions											
1966	$1,943	$1,858	$16	$26	NA	$11	$32	$999	$891	$108	$+944	$944
1967	3,559	3,152	44	301	NA	11	51	3,430	3,353	77	+129	1,073
1968	5,287	4,116	54	1,022	NA	22	74	4,277	4,179	99	+1,010	2,083
1969	5,279	4,473	64	617	NA	11	113	4,857	4,739	118	+422	2,505
1970	5,979	4,881	66	863	NA	11	158	5,281	5,124	157	+698	3.202
1971	5,732	4,921	66	503	NA	48	193	5,900	5,751	150	-168	3,034
1972	6,403	5,731	63	381	NA	48	180	6,503	6,318	185	-99	2,935
1973	10,821	9,944	99	451	$2	48	278	7,289	7,057	232	+3,532	6,467
1974	12,024	10,844	132	471	5	48	523	9,372	9,099	272	+2,652	9,119
1975	12,980	11,502	138	621	7	48	664	11,581	11,315	266	+1,399	10,517
1976	13,766	12,727	143	[4]0	9	141	746	13,679	13,340	339	+88	10,605
1977	15,856	14,114	[5]0	[4]803	12	[6]143	784	16,019	15,737	283	-163	10,442
1978	19,213	17,324	[5]214	688	13	141	834	18,178	17,682	496	+1,035	11,477
1979	22,825	20,768	191	734	16	141	975	21,073	20,623	450	+1,751	13,228
1980	26,097	23,848	244	697	18	141	1,149	25,577	25,064	512	+521	13,749
1981	35,725	32,959	276	659	22	207	1,603	30,726	30,342	384	+4,999	18,748
1982	37,998	34,586	351	808	24	207	2,022	36,144	35,631	513	[7]-10,583	8,164
1983	44,570	37,259	358	878	27	[8]3,456	2,593	39,877	39,337	540	+4,693	12,858
1984	46,720	42,288	351	752	33	250	3,046	43,887	43,257	629	+2,834	15,691
1985	51,397	47,576	371	766	41	[9]-719	3,362	48,414	47,580	834	[10]+4,808	20,499
1986	59,267	54,583	364	566	43	91	3,619	50,422	49,758	664	[10]19,458	39,957

[1] Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income.
[2] Includes cost of peer review organizations beginning with the implementation of the prospective payment system on October 1, 1983.
[3] Includes costs of experiments and demonstration projects.
[4] No transfer was made in 1976 because of the change in transfer dates from December to March. The 1977 transfer was for benefits and administrative expenses during the 15-month period beginning July 1976 and ending September 1977.
[5] No transfer was made in 1977 because of the change in transfer dates from August to June. The 1978 transfer was for contributions during the 5-quarter period covering the transition quarter and fiscal year 1977.
[6] Includes $2 million in reimbursement from general revenues for costs arising from the granting of deemed wage credits to persons of Japanese ancestry who are interned during World War II.
[7] Includes a loan of $12,437 million to the Old Age and Survivors Insurance (OASI) trust fund.
[8] Includes the lump sum general revenue transfer of $3,456 million provided for by section 151 of Public Law 98-21.
[9] Includes the lump sum general revenue adjustment of $805 million, as provided for by section 151 of Public Law 98-21.
[10] Includes repayment of $1,824 million in 1985 and $10,613 million in 1986 in loans to OASI trust fund.

NOTE: Totals do not necessarily equal the sum of rounded components.

SOURCE: Board of Trustees, Federal Hospital Insurance Trust Fund: *1988 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund.* Washington. U.S. Government Printing Office, May 5, 1988.

Table 3.23

Operations of the Medicare supplementary medical insurance trust fund: Calendar years 1966-86

Year	Income				Disbursements			Trust fund	
	Total income	Premiums from participants	Government contributions[1]	Interest on investments and other income[2]	Total disbursements	Benefit payments	Administrative expenses	Net change	Yearend balance[3]
	Amount in millions								
1966	$324	$322	$0	$2	$203	$128	$75	$+121	$122
1967	1,597	640	933	24	1,307	1,197	110	+290	412
1968	1,711	832	858	21	1,702	1,518	184	+9	421
1969	1,839	914	907	18	2,061	1,865	196	-222	199
1970	2,201	1,096	1,093	12	2,212	1,975	237	-11	188
1971	2,639	1,302	1,313	24	2,377	2,117	260	+262	450
1972	2,808	1.382	1,389	37	2,614	2,325	289	+194	643
1973	3,312	1,550	1,705	57	2,844	2,526	318	+468	1,111
1974	4,124	1,804	2,225	95	3,728	3,318	410	+396	1,506
1975	4,673	1,918	2,648	107	4,735	4,273	462	-62	1,444
1976	5,977	2,060	3,810	107	5,622	5,080	542	+355	1,799
1977	7,805	2,247	5,386	172	6,505	6,038	467	+1,300	3,099
1978	9,056	2,470	6,287	299	7,755	7,252	503	+1,301	4,400
1979	9,768	2,719	6,645	404	9,265	8,708	557	+503	4,902
1980	10,874	3,011	7,455	408	11,245	10,635	610	-371	4,530
1981	15,374	[4]3,722	[4]11,291	361	14,028	13,113	915	+1,346	5,877
1982	16,580	[4]3,697	[4]12,284	599	16,227	15,455	772	+353	6,230
1983	19,824	4,236	14,861	727	18,984	18,106	878	+840	7,070
1984	23,180	5,167	17,054	959	20,552	19,661	891	+2,628	9,698
1985	25,106	5,613	18,250	1,243	23,880	22,947	933	+1,226	10,924
1986	24,665	5,722	17,802	1,141	27,299	26,239	1,060	-2,634	8,291

[1] The payments shown as being from the general fund of the U.S. Treasury include certain interest-adjustment items.

[2] Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income.

[3] The financial status of the program depends on both the total assets and the liabilities of the program.

[4] Section 708 of title VII of the Social Security Act modified the provisions for the delivery of social security benefit checks when the regularly designated delivery day falls on a Saturday, Sunday, or legal public holiday. Delivery of benefit checks normally due January 1, 1982, occurred on December 31, 1981. Consequently, the supplementary medical insurance (SMI) premiums withheld from the checks ($264 million) and the general revenue matching contributions ($883 million) were added to the SMI trust fund on December 31, 1981. These amounts are excluded from the premium income and general revenue income for calendar year 1982.

SOURCE: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1988 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.* Washington. U.S. Government Printing Office, May 5, 1988.

Since 1972 Amendments to the Social Security Act, the major source of income for the SMI trust fund has been Federal Government contributions, which made up 72 percent of total income in calendar year 1986. Enrollees' premiums made up 23 percent, and the remainder was interest on investments.

Administration

Fiscal intermediaries

Groups or associations of providers may nominate a national, State, or other public or private agency or organization to be their fiscal intermediary for services covered by the hospital insurance (HI) portion of Medicare. Under an agreement with the Secretary of DHHS, the fiscal intermediary determines reasonable costs for covered items and services, makes payment, and guards against unnecessary use of covered services. Under the agreement, the intermediary may also furnish consultative services to assist providers in establishing and maintaining the fiscal records needed to qualify as providers of service, to serve as a center for communicating with providers, or to audit provider records. In addition, HI intermediaries make payments for outpatient hospital services and home health services covered by SMI. In Table 3.24, workload and cost data for the HI intermediaries are summarized for fiscal years 1975-86.

Until the institution of Medicare's PPS to hospitals, Medicare providers were paid by a retrospective cost-based system. The retrospective cost-based system continues to apply to SNFs and HHAs but not to most hospitals. Under PPS, which began October 1983, most hospitals providing inpatient services to Medicare enrollees are no longer paid on a reasonable-cost basis. Under PPS, the intermediary assigns the appropriate DRG code to each patient bill record and then pays the hospital a predetermined fixed rate for each discharge according to the DRG. In general, PPS payments for a given case are considered full payment for the care received except for deductible and coinsurance amounts. Additional "pass through" payments for medical education and capital costs are made in accordance with formulas contained in legislation.

For providers still paid on the basis of reasonable costs (i.e., SNFs and HHAs), the reasonable costs of services are determined by regulations of the Secretary of DHHS. Charges for covered services generally are submitted by the provider, who is reimbursed for reasonable costs of covered services less the deductible and coinsurance amounts. The beneficiary pays these amounts and also pays for noncovered services.

The provider's intermediary reviews claims for payment and pays the provider. Payments for claims are made on the basis of interim rates established by both provider and intermediary. Final settlement for each provider's operating year is based on the provider's cost report and is subject to an independent audit.

Table 3.24

Medicare hospital insruance intermediary workload and cost data: Fiscal years 1975-86

Year	Cost and fixed-price contractors: Bills processed: Number in thousands	Index	Administrative cost: Amount in millions	Index	Amount per bill	Index	Cost contractors' bill-processing cost: Amount in millions	Index	Amount per bill	Index
1975	25,723.4	100.0	$151.8	100.0	$5.90	100.0	—	—	—	—
1976	25,898.7	100.7	164.8	108.6	5.70	96.6	—	—	—	—
1977	32,119.0	124.1	182.3	120.1	5.68	96.3	—	—	—	—
1978	34,862.4	135.5	191.3	126.0	5.49	93.1	—	—	—	—
1979	36,410.1	141.5	201.5	132.7	5.54	93.9	—	—	—	—
1980	39,789.3	154.7	216.0	142.3	5.43	92.0	—	—	—	—
1981	42,539.8	165.4	234.6	154.5	5.52	93.6	—	—	—	—
1982	45,551.7	177.1	231.9	152.8	5.09	86.3	—	—	—	—
1983	48,688.9	189.3	261.8	172.5	5.38	91.2	$104.6	100.0	$2.45	100.0
1984	50,216.0	295.2	295.7	194.8	5.89	99.8	111.7	106.8	2.64	107.8
1985	58,814.1	228.6	336.3	221.5	5.72	96.9	114.8	109.7	2.33	95.1
1986	65,101.3	253.1	362.4	238.7	5.57	94.4	111.3	106.4	1.97	80.4

SOURCE: Health Care Financing Administration, Bureau of Program Operations, Office of Financial Operations: Data from the Division of Contractor Financial Management.

Table 3.25

Medicare supplementary medical insurance carrier workload and cost data: Fiscal years 1975-86

Year	Cost-and fixed-price contractors: Claims processed: Number in thousands	Index	Administrative cost: Amount in millions	Index	Amount per claim	Index	Cost contractors' claims-processing cost: Amount in millions	Index	Amount per claim	Index
1975	80,613.7	100.0	$258.7	100.0	$3.21	100.0	—	—	—	—
1976	92,399.5	114.6	290.2	112.2	3.14	97.8	—	—	—	—
1977	108,126.3	134.1	322.6	124.7	2.98	92.8	—	—	—	—
1978	120,439.7	149.4	344.6	133.2	2.86	89.1	—	—	—	—
1979	133,494.9	165.6	375.3	145.0	2.81	87.5	—	—	—	—
1980	152,312.6	188.9	398.0	153.8	2.61	81.3	—	—	—	—
1981	169,541.7	210.3	450.5	174.1	2.66	82.9	—	—	—	—
1982	185,769.6	217.0	458.8	169.7	2.47	78.2	—	—	—	—
1983	204,048.8	253.1	485.8	187.8	2.38	74.1	$402.7	100.0	$2.05	100.0
1984	224,676.9	278.7	515.8	199.4	2.30	71.7	434.8	108.0	2.04	99.5
1985	265,936.3	329.9	599.2	231.6	2.25	70.1	476.3	118.3	1.88	91.7
1986	296,397.5	367.7	618.7	239.2	2.09	65.1	481.5	119.6	1.72	83.9

SOURCE: Health Care Financing Administration, Bureau of Program Operations, Office of Financial Operations: Data from the Division of Contractor Financial Management.

Table 3.26

Number of Medicare risk plans and number of Medicare enrollees, by size of plan: December 1987-88

Size of Medicare enrollment in risk plan	Number of plans: 1987	1988	Medicare enrollees: 1987	1988	Percent change
All plans	146	154	990,299	1,062,712	7.3
0-99	5	28	283	126	-55.5
100-499	17	13	4,684	3,474	-25.8
500-999	14	11	9,938	7,457	-25.0
1,000-4,999	63	57	166,945	149,695	-10.3
5,000-9,999	24	20	169,836	147,923	-12.9
10,000-19,999	15	16	213,557	229,688	7.6
20,000-49,999	4	5	115,558	159,610	38.1
50,000 or more	4	4	309,498	364,739	17.8

NOTE: Medicare risk plans comprise health maintenance organizations and competitive medical plans.

SOURCE: Health Care Financing Administration, Office of Prepaid Health Care: Data from the Division of Contract Administration.

Supplementary medical insurance carriers

The Secretary of DHHS contracts with carriers to perform certain administrative duties under SMI. Carriers compute reasonable charges, make payments, determine whether claims are for covered services, and deny claims for noncovered services and unnecessary use of services. Workload and cost data for SMI carriers for fiscal years 1975-86 are presented in Table 3.25.

Claims for SMI benefits may be submitted to the carrier by the patient or by the provider. Patients who submit claims (itemized bills) directly to the carrier receive direct payment for covered services but remain responsible for the physician's (or supplier's) bill. Beginning October 1, 1990, physicians are required to submit the bill. Physicians no longer have the option of requiring the beneficiary to file the claim.

A physician or other supplier of services may accept assignment, accepting the reasonable charge as determined by the carrier as the total charge. The physician (or supplier) submits the bill, and the carrier reimburses 80 percent of the reasonable charge less the deductible amount. The patient is then responsible for the remaining 20 percent of the allowed charge and for any deductible.

Private health plan option

TEFRA 1982 allowed HCFA to contract with health maintenance organizations (HMOs) and competitive medical plans (CMPs) on a prospective capitation payment basis for the provision of health care services to Medicare beneficiaries. Regulations to implement TEFRA were published in January 1985. HCFA signed the first such "risk" contract in April 1985. As of December 1988, there were 154 risk plans with about 1.1 million enrollees (Table 3.26).

TEFRA made three major changes in the previous HMO legislation. First, it provided for a payment mechanism by which HCFA would pay contracting plans 95 percent of the adjusted average per capita cost (AAPCC) for each enrolled beneficiary. The AAPCC is HCFA's actuarial estimate of the amount that would be paid for Medicare-covered services if they were furnished locally by fee-for-service payments. The AAPCC payment rates are adjusted for demographic factors such as age and sex of the Medicare enrollees and are published each September for use in the following calendar year. If the actual costs of services are higher than the AAPCC payment rate, the risk plan suffers a loss. A portion of the savings are required to be used by the plans to provide added benefits or to lower premiums.

Second, TEFRA legislated the "lock-in" provision. This means that Medicare enrollees agree to go through or to the HMO for all health care services. If enrollees do not obtain authorization for care from the HMO or CMP (other than for emergency or urgently needed services), neither the HMO or CMP nor HCFA will pay for these services.

Third, TEFRA allowed HCFA to contract with CMPs as well as federally qualified HMOs. CMPs are determined eligible by HCFA through a process similar to that used for Federal HMO qualification. However, some organizations may find it easier to qualify as a CMP. For example, CMPs may use experience rating to set their commerical premiums wheras HMOs must use community rating to set their commercial premiums

There are advantages to enrollees, Government, and industry as a result of the TEFRA risk-contract program. Enrollees usually receive benefits not covered by regular Medicare, pay predictable monthly premiums, and do not submit Medicare claims forms. The Government is able to provide access to health care that is rendered in an effective and efficient manner while promoting competition between prepaid plans and fee-for-service medical care. The industry receives fixed monthly payments, can contract with HCFA in the same way as their commercial clients, and can offer services to the virtually untapped market of Medicare beneficiaries.

Medicare statistical system

The Medicare statistical system provides data for analyzing and evaluating the program's effectiveness. The system consists of four major computer files: the health insurance master, the provider of service, the HI claims, and the SMI payment records files.

The health insurance master file contains records for each aged and disabled enrollee and includes data on the enrollee's type of entitlement, deductible status, benefit period status, and benefits used. This file provides population data for the program and is the base used in computing a variety of user rates by age, sex, race, and residence.

The provider of service file contains information on hospitals, home health agencies, skilled nursing facilities, independent clinical laboratories, suppliers of portable X-ray or outpatient physical therapy services, and all other providers and suppliers of services that participate in Medicare. This file consists of data from two types of forms, the provider application for participation and the certification-and-transmittal form. For hospitals, it includes data on the number of beds, type of ownership, and other characteristics. Provider data are updated regularly.

The HI claims file contains information on enrollees' entitlement and the extent to which they have used covered benefits. When an enrollee uses a participating medical facility (for example, a hospital or SNF), admission and billing forms are forwarded to HCFA's Central Office. All benefit period information needed by intermediaries is recorded in this office. Information is included on stays in certain nonparticipating institutions and days of care not covered or reimbursable under the program. The admission and billing forms contain both a Medicare enrollee identification number and a provider number. A computer tape record of these data when matched with enrollee entitlement and provider tapes, forms a statistical research tape that contains enrollee, provider, use-of-service, and cost data for each enrollee. As part of the data sampling process, information on diagnoses and surgical procedures (the basis of the hospital data in this report) is obtained for a 20-percent sample of hospitalized enrollees.

The HCFA central SMI payment records file is used to inform carriers whether or not enrollees have met the deductible. It also provides information on amounts paid by carriers for physicians' services and for other SMI-covered services and supplies. A bill summary file is derived from a sample of the SMI payment records file for statistical research.

To better meet Medicare's data needs on physicians' reimbursement, the following four files are generated from all SMI carrier service data.

- A procedure file contains complete counts of all physician medical procedures, medical supplies, amounts charged, and amounts paid. This file provides complete information on Medicare physician and supplier services.
- A prevailing charge file provides prevailing charge information for each service in the procedure file. This allows HCFA to study and forecast payment levels more accurately.
- A provider file contains data from submitted claims on all services rendered by a sample of physicians and suppliers. This allows study of the effect of program changes on physicians' service practices and permits longitudinal analysis of these practices.
- A beneficiary file provides a complete record, from submitted claims, of services received by a sample of beneficiaries. This permits linkage of information on beneficiary use of physicians' and suppliers' services to already existing files containing data on the use of HI services.

These four files supplement data currently available and have been prepared annually beginning with 1983. These files are used by numerous bureaus and offices in HCFA. In the Office of Research and Demonstrations, for example, they are used to provide data and analysis on specific procedures, physician practices, and patient episodes.

The Medicare statistical system enables HCFA to prepare a wide variety of research studies on the use of and reimbursement for Medicare services. Data from the system provide information about enrollee use of benefits for a point in time or over an extended period. Statistical reports are produced on enrollment, characteristics of participating providers, reimbursements, and services used.

Medicare also has implemented the Continuous Medicare History Sample (CMHS) beginning with 1974 data. CMHS provides longitudinal data on Medicare program use by a sample of enrollees. The CMHS files consist of data from all of the Medicare user files for a number of years. Selected data from the enrollment and user files have been combined into one record for each sample person to acquire specific person data.

CMHS is a 5-percent probability sample of Medicare health insurance claim numbers. New enrollees whose claim numbers place them in CMHS are added to the sample, and the records for enrollees whose Medicare coverage ends are retained in the file. The ability to link different data files over a period of years is a key feature of CMHS and the Medicare statistical system. It permits detailed analysis of specific groups of enrollees over time.

4. Medicaid: Description and data

The Medicaid program is designed to provide medical care to certain low-income individuals and families. States administer their Medicaid programs within broad Federal requirements and guidelines. These requirements allow States considerable discretion in determining eligibility, service coverage, and reimbursement provisions. Medicaid is financed jointly through Federal and State funds. In fiscal year 1986, Medicaid accounted for $41.0 billion in Federal and State payments for medical services to 22.5 million recipients.

Detailed information is provided in this chapter on the following topics regarding Medicaid: eligibility; service coverage and limitations; administration and financing, including provider reimbursement, financing, and administrative structure; utilization, including State-level data on Medicaid recipients by eligibility category, demographic group, and service category; payments, also including State-level data by eligibility category, demographic group, and service category; the Medicaid data system; and a discussion of the special topic of recent Medicaid expansions in the area of maternal and child health.

Eligibility

Federal law mandates that certain groups must be covered by State Medicaid programs. These mandatory groups generally relate to two broad categories. The first category is low-income families with dependent children. Historically this group has been composed of families receiving cash assistance through the Aid to Families with Dependent Children (AFDC) program and various AFDC-related groups. Recent Federal legislation, however, has expanded Medicaid eligibility in this area to include other low-income families. The second category is the low-income aged and low-income disabled. Generally, this category includes individuals receiving cash assistance through the Supplemental Security Income (SSI) program and certain SSI-related groups. Individuals in these mandatory coverage groups, along with certain optional groups (discussed next) are referred to as categorically needy.

States have the option to cover certain additional eligibility groups in their Medicaid programs. These optional groups can be divided into three basic groupings. The first two are composed of additional groups that the State may cover that are related to the two mandatory categories noted previously (i.e., families with dependent children, the aged and the disabled). These groups are referred to as optional categorically needy. The third is the medically needy. These are individuals whose incomes or resources are above levels established for the categorically needy but who have incurred large medical expenses.

Finally, States can offer Medicaid eligibility to additional groups that are not included in the mandatory or optional groups noted above, but they do not receive Federal matching payments for services rendered to these individuals. Such groups are referred to as State-only coverage groups.

We discuss these eligibility groups in more detail next.

Mandatory coverage groups

Low-income families with dependent children

States must provide Medicaid to all families receiving cash payments through AFDC (Title 42, Code of Federal Regulations [hereafter abbreviated 42 CFR] 435.110). AFDC payments are made to low-income families with children where one parent is absent or incapacitated. Under AFDC, each State establishes a need standard for determining AFDC eligibility. The need standard is the income that the State decides is necessary for a family of a given size to purchase basic necessities such as food, clothing, shelter, household supplies, and personal care items. In order to be considered eligible for AFDC payments (and, therefore, also eligible for Medicaid), a family must pass two income tests. First, the applicant's countable income must be less than the need standard, where countable income is defined to be gross income minus certain disregards (e.g., child care costs and a standard monthly allowance). Second, an applicant's gross income must be less than 185 percent of the State's need standard.

AFDC applicants also must meet resource limits. By Federal law the value of a family's real and personal property cannot exceed $1,000. This amount does not include the value of the family's home and up to $1,500 equity in an automobile. In addition, States may exclude from this limit the value of items essential to day-to-day living such as clothing and furniture.

Families meeting these income and resource requirements may be eligible to receive AFDC payments. Note, however, that each State also sets a maximum AFDC payment standard for a family of a given size. Although in some States the payment standard is equal to the need standard, there are a number of States in which the payment standard is less than the need standard. In order to be eligible for Medicaid through the AFDC cash-assistance provision, the family must actually receive AFDC payments. AFDC payments are determined by subtracting countable income from the payment standard. Thus, a family's countable income also must be below the payment standard in order to actually receive an AFDC payment, and thereby be eligible for Medicaid. Families whose countable income is below the State's need standard but above the payment standard may be eligible for Medicaid through an optional eligibility provision (see later).

The AFDC need standard and maximum payment amount by jurisdiction and size of family as of September 1989 are presented in Table 4.1. As can be seen, there is wide variation in the standards established by the States for eligibility for AFDC payments. For example, maximum payments for a family of three ranged from $118 per month in Alabama to $809 in Alaska.

States have the option to cover additional groups in their AFDC programs. If a State chooses to offer

Table 4.1

Monthly need standard and maximum payment for Aid to Families with Dependent Children, by size of family and by State: September 1989

State	Family of 1		Family of 2		Family of 3		Family of 4	
	Need standard	Maximum payment	Need standard	Maximum payment	Need standard	Maximum paymemt	Need standard	Maximum payment
Alabama	$390	$59	$479	$88	$571	$118	$670	$147
Alaska	453	453	719	719	809	809	899	899
Arizona	367	173	494	233	621	293	748	353
Arkansas	280	81	560	162	705	204	850	247
California	341	341	560	560	694	694	824	824
Colorado	253	214	331	280	421	356	510	432
Connecticut	340	340	452	452	555	555	652	652
Delaware	184	184	247	247	333	333	402	402
District of Columbia	450	248	560	309	712	393	870	480
Florida	498	163	668	220	838	287	1,008	338
Georgia	229	151	347	229	414	273	488	322
Hawaii	572	357	768	480	964	602	1,016	725
Idaho	365	208	446	254	554	315	627	357
Illinois	427	198	539	250	740	342	835	386
Indiana	155	139	255	229	320	288	385	346
Iowa	213	176	421	347	497	410	578	476
Kansas	243	243	330	330	410	410	480	480
Kentucky	394	162	460	196	526	228	592	285
Louisiana	245	72	472	138	658	190	809	234
Maine	299	207	470	326	632	438	794	551
Maryland	243	175	428	309	548	396	660	477
Massachusetts	392	392	486	486	579	579	668	668
Michigan	348	291	466	388	575	479	702	585
Minnesota	250	250	437	437	532	532	621	621
Mississippi	218	60	293	96	368	120	443	144
Missouri	145	134	250	232	312	289	365	338
Montana	256	212	346	286	434	359	523	433
Nebraska	222	222	293	293	364	364	435	435
Nevada	350	210	450	270	550	330	650	390
New Hampshire	380	380	442	442	506	506	563	563
New Jersey	162	162	322	322	424	424	488	488
New Mexico	156	156	210	210	264	264	317	317
New York	334	334	439	439	539	539	639	639
North Carolina	354	177	462	231	532	266	582	291
North Dakota	209	209	313	313	386	386	472	472
Ohio	440	191	606	263	739	321	914	397
Oklahoma	291	201	364	252	471	325	583	403
Oregon	289	289	369	369	432	432	526	526
Pennsylvania	298	195	461	315	587	402	724	490
Rhode Island	321	321	440	440	543	543	620	620
South Carolina	249	123	335	165	419	206	504	248
South Dakota	265	265	333	333	377	377	421	421
Tennessee	198	94	297	141	387	184	472	224
Texas	235	75	493	158	574	184	691	221
Utah	299	224	414	310	516	387	603	452
Vermont	670	448	817	547	973	651	1,090	730
Virginia	174	157	257	231	322	291	386	347
Washington	579	314	733	397	907	492	1,068	578
West Virginia	289	145	401	201	497	249	623	312
Wyoming	195	195	320	320	360	360	390	390

NOTE: In a number of States, need standards and payment amounts vary depending on factors such as region and season and what components are included in the standard (e. g., rental allowance). In all such cases, the region with the highest concentration of recipients and/or the highest seasonal rate is displayed.

SOURCE: National Governors' Association: *A Catalogue of State Medicaid Program Changes.* Washington. National Governors' Association, 1989.

AFDC cash assistance to such families it must also offer Medicaid coverage. Until recently the most important of these optional AFDC groups was two-parent families in which the primary breadwinner was an unemployed parent (AFDC-UP). As of April 1, 1990, AFDC-UP became mandatory for AFDC programs in all States.

In addition to offering Medicaid eligibility to recipients of cash assistance through AFDC, States must also offer Medicaid coverage to additional low-income families. As of July 1, 1990, Medicaid eligibility is also mandatory for the following groups:

- Children up to 6 years of age and pregnant women whose family income is below 133 percent of the Federal poverty level (Public Law 100-239, Section 6401). The Federal poverty level for a family of three in 1989 was $10,060 per year. Pregnant women covered by this provision are eligible for all covered pregnancy-related services. States may also cover postpartum services until approximately 2 months after the birth.
- All children up to 7 years of age in families who meet AFDC income and resource standards (42 CFR 435.116). Note that this includes children who do not meet AFDC definitions of a dependent child, such as children in two-parent low-income families. Children eligible under this provision are often referred to as mandatory Ribicoff children. Recall that coverage is now mandatory for children up to 6 years of age in families whose income is below 133 percent of poverty. This provision thus basically covers children age 6 up to age 7.
- Families terminated from AFDC because of increased earnings or hours of employment (42 CFR 435.112). The State must continue to provide Medicaid coverage to such families for 12 months beyond the date of AFDC termination. For the final 6 months, the State may require families to pay premiums for continued Medicaid coverage, offer reduced benefits, or select alternative coverage options.
- Individuals who are ineligible for AFDC because of requirements that do not apply under Medicaid (42 CFR 435.113). For example, certain individuals who fail to register for a work incentive program may be made ineligible for AFDC. Such restrictions do not apply in Medicaid, so the person cannot be made ineligible for Medicaid on these grounds.
- Individuals in the 1972 pass-through group (42 CFR 435.114). These are individuals who would be eligible for AFDC except for increased income as a result of the 1972 increase in the Old Age, Survivors, and Disability Insurance benefit (OASDI). Few individuals should still be eligible under this provision.
- Individuals deemed to be receiving AFDC (42 CFR 435.115). This group includes individuals who are denied AFDC payments solely because the payments would be less than $10, individuals who would be receiving AFDC payments if they were not participating in a work supplementation program, and individuals who are denied AFDC payments solely because the State is recovering an overpayment.
- Newborn children of women who are eligible for Medicaid on the date of the child's birth (42 CFR 435.117). The child is automatically deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible up to 1 year as long as the mother remains eligible and the child is a member of the woman's household. This provision insures Medicaid coverage for newborn children while formal eligibility determinations are completed.
- Children for whom adoption assistance or foster care maintenance payments are made (42 CFR 435.118).

Low-income aged and disabled

Just as AFDC is the basic reference point for Medicaid eligibility for families with dependent children, SSI is the reference point for Medicaid eligibility for the aged and the disabled. Prior to 1974, States were responsible for cash assistance to low-income aged and disabled and thus had broad flexibility in setting eligibility requirements. However, in 1974, the SSI program was established and largely replaced the State programs. SSI is a Federal cash assistance program for low-income aged and disabled that has standard eligibility requirements. Because SSI requirements were more restrictive than those existing in some States and less restrictive than others, States were given two basic options in offering Medicaid eligibility to the aged and the disabled receiving cash assistance. First, a State could make all SSI recipients eligible for Medicaid. Second, the State could limit Medicaid eligibility to individuals who meet requirements more restrictive than those for SSI. The latter is referred to as the 209(b) option. States choosing each of these options are shown in Table 4.2. As of January 1988, 37 States (including the District of Columbia) chose to offer Medicaid eligibility to all SSI recipients and 14 States chose to use more restrictive criteria.

States choosing the first option must provide Medicaid coverage to all individuals receiving cash assistance through SSI. To be eligibile for SSI, an aged or disabled individual must have countable income below benefit standards (countable income is defined to be gross income minus certain disregards, such as the first $20 of monthly social security benefits and a certain portion of earned income). In 1988, the Federal SSI benefit standard was $354 per month for an individual and $532 per month for a couple.

Aged and disabled applicants also must meet resource standards to be eligible for SSI, and thus Medicaid. As of 1988, countable resources could not exceed $1,900 for an individual and $2,850 for a couple. Examples of assets that are not considered countable resources for SSI eligibility include the applicant's home, $2,000 equity value of household goods and personal effects, $4,500 equity in an automobile, and burial spaces.

States electing this option can either have the Social Security Administration determine which people are eligible for SSI and automatically issue Medicaid identification cards to them (referred to as 1634 agreements), or the State can require SSI recipients to file a separate Medicaid application with the State.

Table 4.2

State selection of Supplemental Security Income (SSI) criteria versus option 209(b) for Medicaid eligibility determination, by State: January 1988

State	SSI criteria	Option 209(b)	State	SSI criteria	Option 209(b)
Alabama	X		Missouri		X
Alaska	X		Montana	X	
Arizona	X		Nebraska		X
Arkansas	X		Nevada	X	
California	X		New Hampshire		X
Colorado	X		New Jersey	X	
Connecticut		X	New Mexico	X	
Delaware	X		New York	X	
District of Columbia	X		North Carolina		X
Florida	X		North Dakota		X
Georgia	X		Ohio		X
Hawaii		X	Oklahoma		X
Idaho	X		Oregon	X	
Illinois		X	Pennsylvania	X	
Indiana		X	Rhode Island	X	
Iowa	X		South Carolina	X	
Kansas	X		South Dakota	X	
Kentucky	X		Tennessee	X	
Louisiana	X		Texas	X	
Maine	X		Utah		X
Maryland	X		Vermont	X	
Massachusetts	X		Virginia		X
Michigan	X		Washington	X	
Minnesota		X	West Virginia	X	
Mississippi	X		Wisconsin	X	
			Wyoming	X	

NOTES: Under option 209(b), States can limit Medicaid eligibility to individuals who meet more restrictive requirements than those for SSI. Thirty-seven States chose to offer Medicaid eligibility to all SSI recipients, and 14 States chose option 209(b).

SOURCE: (Congressional Research Service, 1988).

States choosing the 209(b) option can have more restrictive eligibility requirements for Medicaid than those in effect for SSI. These more restrictive requirements can apply to the definition of disability, income standards, or resource standards, but can be no more restrictive than those in effect in the State's Medicaid plan prior to the implementation of SSI. In addition, States electing this option must allow applicants to deduct medical expenses from countable income in the eligibility determination process. This is often referred to as the 209(b) spend-down.

All States also must offer Medicaid eligibility to the following aged and disabled groups:

- Aged and disabled individuals whose incomes are below 90 percent of the poverty level (phased in to 100 percent by 1992) and whose resources are below twice the standard allowed under the SSI program (Public Law 100-234, title III, section 301). This group is referred to as qualified Medicare beneficiaries (QMBs). The Federal poverty level in 1988 was $5,672 per year for an individual age 65 or over living alone and $7,156 for a couple. Individuals eligible under this provision do not receive full coverage of Medicaid services. Medicaid pays only Medicare premiums, copayments, and deductibles for this group.
- Disabled individuals who would be eligible for cash assistance except for earned income (Social Security Act, section 1619[b]). As noted previously, Medicaid eligibility is linked to receipt of cash assistance through the SSI program. Disabled individuals with high medical expenses often cannot afford to lose their medical coverage through Medicaid, and thus SSI income limits could act as a deterrant for employment for those disabled who are able to work. This provision is designed to reduce this deterrent.
- Disabled individuals who would be eligible for social security disability insurance (SSDI) except for earned income (Public Law 100-239, section 6408[d]). Such individuals must have incomes below 200 percent of the Federal poverty level and resources below twice the standard allowed under the SSI program. States are required to cover Medicare Part A premiums and cost sharing for this group. Note that the SSDI program is different from the SSI program. SSDI is the basic disability insurance program administered by the Social Security Administration for disabled individuals who have obtained sufficient quarters of employment. It is not viewed as a cash assistance program, as is SSI. Disabled individuals enrolled in SSDI are eligible for Medicare (after a 24-month waiting period). The SSDI program has an earnings limit called the substantial gainful activity (SGA) level. If a disabled person earns more than the SGA level, he or she loses SSDI and thus Medicare coverage. Under this Medicaid provision, Medicaid pays Part A premiums and copayments to the Medicare program for these individuals, allowing them to maintain their Medicare coverage.
- Aged and disabled individuals who are ineligible for cash assistance because of requirements that do not apply under Medicaid (42 CFR 435.122).
- Aged and disabled individuals in 1972 and 1977 pass-through groups. The 1972 group is made up of individuals who would be eligible for cash assistance except for increased income as a result of the 1972 increase in the OASDI benefit (42 CFR 435.134). The 1977 group is made up of individuals who would be eligible for cash assistance except for the OASDI cost-of-living increase of 1977 (42 CFR 435.135).
- Certain disabled persons (widows, widowers, and certain children) who lost cash assistance because of 1983 changes in the calculation of social security benefits (Social Security Act, section 1634).
- Aged and disabled individuals in 1973 grandfathered groups. These are individuals who would have lost Medicaid eligibility in the transition from State cash to assistance SSI. Several groups are involved. The first is individuals whose countable income was below the State's benefit standards in 1973 but above the SSI levels (42 CFR 435.130). The second group is essential spouses who were eligible under a State plan but did not qualify for SSI because they were neither elderly nor disabled (42 CFR 435.131). The third group is certain individuals who were institutionalized in 1973 but were not eligible for SSI (42 CFR 435.132). The final group is individuals who were eligible as disabled under the State plan in 1973 but did not meet SSI disability requirements (42 CFR 435.133).

Optional coverage groups

States must offer Medicaid eligibility to the groups just described. States also have the option, but are not required, to cover certain additional groups for whom Federal funds are available.

Low-income families with dependent children

States have the option to offer Medicaid eligibility to the following families and children (States choosing some of these options are shown in Table 4.3):

- Infants under age 1 and pregnant women in families whose income is from 133 to 185 percent of the Federal poverty level for a family of comparable size. (Recall that coverage is mandatory for pregnant women and for infants in families whose income is below 133 percent of poverty.) As of July 1989, 15 States covered infants and pregnant women up to the maximum of 185 percent of the poverty level (note that in July 1989, coverage was mandatory only up to 75 percent of the poverty level).
- Children age 6 to 8 in families whose income is below 100 percent of the Federal poverty level (Public Law 100-239, section 6401). Recall that coverage is mandatory for children up to 6 years of age in families whose income is below 133 percent of the poverty level and for children up to 7 years of age in families with incomes below AFDC limits.

Table 4.3

Coverage of low-income families with dependent children under selected optional Medicaid eligibility groups, by State: 1989

State	Infants and pregnant women under percent of poverty	Ribicoff children		State	Infants and pregnant women under percent of poverty	Ribicoff children	
		All under age:	Reasonable classifications under age:			All under age:	Reasonable classifications under age:
Alabama	100		18	Missouri	100		21
Alaska	100	21		Montana	100		21
Arizona	100	18		Nebraska	100	21	
Arkansas	100	18		Nevada	75		19
California	185	21		New Hampshire	75		18/19
Colorado	75		21	New Jersey	100	21	
Connecticut	185	21		New Mexico	100		18/21
Delaware	100		21	New York	185	21	
District of Columbia	100	21		North Carolina	100	21	
Florida	150	18		North Dakota	75	21	
Georgia	100	18		Ohio	100	21	
Hawaii	[2]185		19/21	Oklahoma	100	21	
Idaho	75		18/21	Oregon	85		18/21
Illinois	100	18		Pennsylvania	100	21	
Indiana	100		21	Rhode Island	185		18/21
Iowa	185	21		South Carolina	185	18	
Kansas	150	18		South Dakota	100		21
Kentucky	125		19	Tennessee	100	21	
Louisiana	100		18	Texas	130	19	
Maine	185	21		Utah	100	18	
Maryland	185	21		Vermont	185	21	
Massachusetts	185	21		Virginia	100		21
Michigan	185	21		Washington	185		21
Minnesota	185	21		West Virginia	150		18
Mississippi	185	18		Wisconsin	[3]120	18	
				Wyoming	100		19

[1] Coverage of children and pregnant women under 75 percent of the poverty level was mandatory in 1989. Effective April 1, 1990, coverage of children under age 6 and pregnant women under 133 percent of poverty is mandatory.
[2] Future implementation date.
[3] State-funded program covers infants and pregnant women at this level.

NOTES: Data for infants and pregnant women are as of September 1989. Data for Ribicoff children are as of July 1989. Thirty-one States offered coverage to individuals under age 21 (or at State option, under age 20, 19, or 18) who were in families that met Aid to Families with Dependent Children standards but who did not qualify as dependent children (i.e., Ribicoff children); and 20 States offered coverage to reasonable classifications of Ribicoff children under specified ages (which included children in foster homes, subsidized adoptions, intermediate care facilities, or psychiatric institutions).

SOURCE: National Governors' Association: *A Catalogue of State Medicaid Program Changes.* Washington. National Governors' Association, 1989.

- Individuals under age 21 (or at State option age 20, 19, or 18) who are in families that meet AFDC income and resource standards but who do not qualify as dependent children (42 CFR 435.222). Usually this refers to children in two-parent families where the primary breadwinner is employed. States may offer coverage to all such individuals or limit it to reasonable classifications (reasonable classifications include children in foster homes, subsidized adoptions, intermediate care facilities, or psychiatric institutions). Individuals eligible under this provision are often referred to as Ribicoff children. Recall from previous mention that coverage of Ribicoff children up to 7 years of age is mandatory. This option lets States extend the age limit for such children. As of July 1989, 31 States (and the District of Columbia) offered coverage to all such children, and 20 States offered coverage to reasonable classifications of these children.
- Individuals who would be eligible for AFDC but are not receiving it (42 CFR 435.210). This includes individuals who are eligible for AFDC but do not apply for it.
- Individuals who would be eligible for AFDC if they were not in an institution (42 CFR 435.211).
- Individuals who lose their eligibility while enrolled in a health maintenance organization (HMO) (42 CFR 435.212). States can deem such individuals as eligible for Medicaid for up to 6 months from the date of enrollment. Only services provided by the HMO are covered.
- Individuals receiving services through home and community-based waivers (42 CFR 435.217). This group is made up of individuals who would require institutionalization in the absence of services provided through home and community-based waivers and who would be eligible for Medicaid if in an institution.
- Individuals who would be eligible for AFDC if child care costs were paid from earnings (42 CFR 435.220). In some States child care costs are paid by a State agency rather than the applicant and are not deducted when calculating countable income for AFDC eligibility. This provision allows the State to offer Medicaid eligibility to individuals who would be eligible for AFDC if child care costs were paid by the applicant.
- Individuals who would be eligible for AFDC if coverage under the State's ADFC plan were as broad as allowed under title IV-A of the Social Security Act (42 CFR 435.223). For example, recall from previous mention that in some States the AFDC payment standard is less than the need standard and thus is not as large as it could be under title IV-A. A family whose countable income is below the State's need standard but above the payment standard would not automatically be eligible for Medicaid because it would not receive an actual AFDC payment. This provision gives the State the option to offer Medicaid coverage to such families.

Low-income aged and disabled

States also have the option, but are not required, to offer Medicaid coverage to the following aged and disabled groups (States selecting some of these options are shown in Table 4.4):

- Aged and disabled individuals whose income is higher than SSI standards but lower than 100 percent of the Federal poverty level (Social Security Act, section 1902(1)). Note that coverage of this optional group is different from the mandatory coverage of QMBs noted above. States electing this option cover Medicare cost-sharing requirements (premiums, copayments, and deductibles) as well as all additional Medicaid services, but coverage of QMBs is only for Medicare cost sharing.
- Aged and disabled individuals receiving only State supplemental payments (42 CFR 435.230). A number of States supplement the basic SSI benefit payment. This provision gives the States the option to offer Medicaid coverage to individuals who receive these State supplements but not SSI. Thirty-two States covered this group.
- Institutionalized individuals under a special income level (42 CFR 435.231). Through this provision, States have the option to set a special income limit for Medicaid eligibility for individuals in medical institutions. This limit may be no more than 300 percent of the maximum SSI benefit. Thirty States selected this option.
- Disabled children needing institutional-level care who live at home. A disabled child's parents' income is included as countable income for SSI eligibility if the child lives at home. However, if the child resides in an institution, the parents' income is not included after the first month. It is, therefore, possible for a disabled child to be eligible for SSI (and thus also Medicaid) if he lives in an institution but not if he lives at home. For some children institutional-level care can be provided in the home. This provision allows children needing institutional-level care but who live at home to receive Medicaid coverage. It is often referred to as the Katie Beckett provision. Twenty-two States include this optional group.
- Aged and disabled individuals who would be eligible for cash assistance but are not receiving it (42 CFR 435.210). This includes individuals who are eligible but who do not apply.
- Aged and disabled individuals who would be eligible for cash assistance if they were not in an institution (42 CFR 435.211).
- Aged and disabled individuals who lose their eligibility while enrolled in an HMO (42 CFR 435.212). As was the case for families with dependent children, States can deem such individuals as eligible for Medicaid for up to 6 months from the date of enrollment. Only services provided by the HMO are covered.
- Individuals receiving services through home and community-based waivers (42 CFR 435.217).

Table 4.4
Coverage of low-income aged and disabled under selected optional eligibility groups, by State[1]

State	Recipients of State supplemental payments (SSP) only	Institutionalized under special income standard	Katie Beckett provision
Alabama	Y	Y	N
Alaska	Y	Y	N
Arizona	—	—	—
Arkansas	N	Y	Y
California	Y	N	N
Colorado	Y	Y	N
Connecticut	Y	N	Y
Delaware	N	Y	N
District of Columbia	Y	N	Y
Florida	N	Y	N
Georgia	N	Y	Y
Hawaii	[2]Y	N	Y
Idaho	Y	Y	Y
Illinois	Y	N	N
Indiana	Y	N	N
Iowa	Y	Y	N
Kansas	N	N	N
Kentucky	Y	Y	N
Louisiana	N	Y	N
Maine	Y	Y	Y
Maryland	Y	N	N
Massachusetts	Y	N	Y
Michigan	Y	N	N
Minnesota	Y	N	N
Mississippi	N	Y	N
Missouri	Y	N	N
Montana	N	N	Y
Nebraska	Y	N	Y
Nevada	Y	Y	Y
New Hampshire	Y	Y	N
New Jersey	Y	Y	N
New Mexico	N	Y	N
New York	Y	N	N
North Carolina	Y	N	Y
North Dakota	N	N	N
Ohio	Y	N	N
Oklahoma	Y	Y	Y
Oregon	N	Y	Y
Pennsylvania	Y	Y	Y
Rhode Island	Y	Y	Y
South Carolina	Y	Y	N
South Dakota	N	Y	Y
Tennessee	N	Y	N
Texas	N	Y	N
Utah	N	N	Y
Vermont	N	Y	Y
Virginia	Y	Y	N
Washington	Y	Y	Y
West Virginia	N	Y	Y
Wisconsin	Y	N	Y
Wyoming	N	Y	N

[1] Data for recipients of SSP only and for the institutionalized under special income standard are as of the second quarter of 1987. Data for recipients under the Katie Beckett provision are as of March 1988.

[2] Provides automatic Medicaid coverage to only some recipients of SSP only.

NOTES: Y is yes; N is no. Thirty-two States covered some aged and some disabled individuals receiving only SSP; 30 States covered institutionalized individuals under a special income standard; and 22 States covered disabled children needing institutional-level care who live at home (Katie Beckett provision).

SOURCE: (Congressional Research Service, 1988).

Medically needy

Coverage of the medically needy is one of the most important eligibility options available to the State in its Medicaid program. The medically needy are those who meet criteria for categorically needy assistance except for income and/or resources and who have incurred large medical expenses. As can be seen in Table 4.5, 36 States elected to cover this group in fiscal year 1989.

States electing this option establish income and resource standards for medically needy assistance. The income standard can be higher than that in effect for the categorically needy but no higher than 133 percent of the AFDC payment standard for a family of comparable size. The medically needy income standards in effect in 1989 are shown in Table 4.5.

Applicants for medically needy coverage are allowed to deduct certain medical expenses in determining countable income for eligibility determination. This is referred to as the medically needy spend-down provision. Examples of deductible medical expenses include Medicare and other health insurance premiums, deductibles, and coinsurance charges, and expenses incurred for medical services included in the State's Medicaid plan or recognized under State law. This spend-down provision is especially important for granting Medicaid eligibility to the institutionalized who incur very large medical expenses.

Generally, the medically needy resource standard is equal to the highest resource standard used for the comparable categorically needy group, or the highest standard for all categorically needy groups if the State uses only one resource standard.

If a State chooses the medically needy option, it must offer coverage to children under age 18 and pregnant women, but it can choose which other groups to include. For example, it may choose to include the aged and disabled but not parents of dependent children. In addition, a State may offer different benefits to different groups under the medically needy option.

The Federal Government provides funds for services provided to the mandatory and optional groups noted previously. A State may extend Medicaid coverage to individuals who are not in the preceding groups only at its own expense. The Federal Government will not provide assistance in such cases. Persons covered fully at State expense need not meet any of the requirements for categorical eligibility. For example, a young single male over age 21 and living alone could, at State option, receive Medicaid benefits as a State-only eligible.

Service coverage and limitations

The services covered by Medicaid are discussed in this section. Federal regulations mandate that States cover a basic set of services through the Medicaid program, but States have the option to cover a number of additional services. States also have the latitude to impose limitations on the amount, duration, and scope of covered services. Services covered by Medicaid, including mandatory and optional services, and service limitations are discussed in more detail next.

Covered services

Mandatory services

All States must cover the following basic services for all categorically needy recipients.

- Inpatient hospital services, other than services in an institution for mental diseases (42 CFR 440.10).
- Outpatient hospital services (42 CFR 440.20[a]).
- Rural health clinic services (42 CFR 440.20[b]).
- Other laboratory and X-ray services (42 CFR 440.30).
- Skilled nursing facility services for individuals age 21 or over, other than services in an institution for mental diseases (42 CFR 440.40[a]).
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals age 21 or under (42 CFR 440.40[b]).
- Family planning services and supplies for individuals of childbearing age (42 CFR 440.40[c]).
- Physicians' services (42 CFR 440.50).
- Home health services, including nursing services provided on a part-time or intermittent basis, home health aide services, and medical supplies and equipment suitable for use in the home (42 CFR 440.70).
- Nurse-midwife services (42 CFR 440.165).

States selecting the medically needy eligibility option must cover the following services for their medically needy recipients.

- Prenatal care and delivery services for pregnant women (42 CFR 440.220[a]).
- Ambulatory services, as defined in the State plan, for individuals under age 18 and individuals entitled to institutional services (42 CFR 440.220[b]).
- Home health services to any individual entitled to skilled nursing facility services (42 CFR 440.220[c]).
- More comprehensive benefits are required in States that provide institutional services for mental diseases or mental retardation (42 CFR 440.220[d]).

Table 4.5

Medically needy programs in Medicaid and medically needy protected monthly income levels, by State: September 1989

State	Medically needy program	Protected monthly income level			
		Family of 1	Family of 2	Family of 3	Family of 4
Alabama	N	NA	NA	NA	NA
Alaska	N	NA	NA	NA	NA
Arizona	N	NA	NA	NA	NA
Arkansas	Y	$108	$217	$275	$333
California	Y	600	750	934	1,110
Colorado	N	NA	NA	NA	NA
Connecticut	Y	452	601	738	867
Delaware	N	NA	NA	NA	NA
District of Columbia	Y	391	412	524	640
Florida	Y	300	300	383	458
Georgia	Y	208	308	367	433
Hawaii	Y	357	480	602	725
Idaho	N	NA	NA	NA	NA
Illinois	Y	267	333	458	517
Indiana	N	NA	NA	NA	NA
Iowa	Y	466	466	550	633
Kansas	Y	368	475	480	506
Kentucky	Y	217	267	308	383
Louisiana	Y	100	192	258	317
Maine	Y	400	441	591	741
Maryland	Y	375	417	459	500
Massachusetts	Y	483	650	775	891
Michigan	Y	391	525	555	585
Minnesota	Y	466	582	709	828
Mississippi	N	NA	NA	NA	NA
Missouri	N	NA	NA	NA	NA
Montana	Y	368	383	408	433
Nebraska	Y	392	392	492	584
Nevada	N	NA	NA	NA	NA
New Hampshire	Y	382	554	575	597
New Jersey	Y	350	433	566	658
New Mexico	N	NA	NA	NA	NA
New York	Y	459	659	709	850
North Carolina	Y	242	308	358	392
North Dakota	Y	345	400	435	530
Ohio	N	NA	NA	NA	NA
Oklahoma	Y	275	341	433	541
Oregon	Y	385	491	575	701
Pennsylvania	Y	408	425	450	542
Rhode Island	Y	550	592	725	833
South Carolina	N	NA	NA	NA	NA
South Dakota	N	NA	NA	NA	NA
Tennessee	Y	175	192	250	300
Texas	Y	100	211	267	301
Utah	Y	337	413	516	602
Vermont	Y	733	733	875	975
Virginia	Y	250	308	358	400
Washington	Y	396	532	599	667
West Virginia	Y	200	275	290	312
Wisconsin	Y	471	592	689	823
Wyoming	N	NA	NA	NA	NA

NOTES: Y is yes; N is no. In a number of States, protected income varies depending on factors such as region and season and what components are included in the standard (e.g., rental allowance). In all such cases, the region with the highest concentration of recipients and/or the highest seasonal rate is displayed. Thirty-six States had medically needy programs which cover individuals who meet the criteria for categorically needy assistance except for income and/or resources and who incur large medical expenses.

SOURCE: National Governors' Association: *A Catalogue of State Medical Program Changes.* Washington. National Governors' Association, 1989.

Optional services

States have the option, but are not required, to offer the following additional services (States electing to offer each of these optional services as of the start of fiscal year 1990 are presented in Table 4.6):

- Medical or other remedial care provided by other licensed practitioners such as chiropractors, optometrists, and podiatrists (42 CFR 440.60). Twenty-nine jurisdictions cover chiropractic services, 52 cover optometrists' services, and 44 cover podiatrists' services.
- Home health services in addition to the mandatory home health services noted previously, including physical therapy, occupational therapy, speech pathology and audiology services provided by a home health agency (42 CFR 440.70[b][4]).
- Private duty nursing services, defined as nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility (42 CFR 440.80). Twenty-eight jurisdictions cover these services.
- Clinic services (42 CFR 440.90). Fifty-four jurisdictions cover these services.
- Dental services, in addition to those required for persons under age 21 through the State's EPSDT program (42 CFR 440.100). Forty-seven jurisdictions cover these services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (42 CFR 440.110). Thirty-nine jurisdictions cover physical therapy; 28 cover occupational therapy; 36 cover services for individuals with speech, hearing, and language disorders.
- Prescribed drugs, dentures, prosthetic devices, and eyeglasses (42 CFR 440.120). Fifty-three jurisdictions cover prescribed drugs, 39 cover dentures, 50 cover prosthetic devices, and 48 cover eyeglasses.
- Other diagnosic, screening, preventive, and rehabilitative services (42 CFR 440.130). Twenty-two jurisdictions cover diagnostic services, 18 cover screening services, 20 cover preventive services, and 41 cover rehabilitative services.
- Inpatient hospital services, skilled nursing facility (SNF) services, and intermediate care facility (ICF) services for individuals age 65 or over in institutions for mental diseases (42 CFR 440.140). Forty-one jurisdictions cover inpatient services for this population, 25 cover SNF services, and 30 cover ICF services.
- ICF services, other than in institutions for mental diseases (42 CFR 440.150). This includes services in intermediate care facilities for the mentally retarded (ICFs/MR). Fifty-one jurisdictions cover ICF services other than for the mentally retarded, and 50 cover ICF/MR services.
- Inpatient psychiatric services for individuals under age 21 (42 CFR 440.160). Thirty-eight jurisdictions cover these services.
- Any other medical or remedial care recognized under State law and specified by the Secretary (42 CFR 440.170). Included are services such as transportation to secure medical treatment (52 jurisdictions), SNF services for individuals under age 21 (50 jurisdictions), emergency hospital services (44 jurisdictions), and personal care services in a recipient's home (26 jurisdictions).
- Home or community-based services, such as case management services, homemaker services, home health aid services, personal care services, adult day health services, habilitation services, and respite care services (42 CFR 440.180). Thirty-one jurisdictions cover case-management services.

Service limitations

Whatever package of services it chooses, a State may place limits on the amount, duration, and scope of the services offered. However, general restrictions apply as follows:

- Statewide operation. A State's Medicaid plan must be in effect throughout the entire State (42 CFR 431.50). Thus, with a few exceptions, the services covered in one part of the State cannot be different from those covered in a different part of the State.
- Free choice of providers. Recipients may obtain covered services from any qualified Medicaid provider (42 CFR 431.51).
- Sufficiency of amount, duration, and scope. Each covered service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition (42 CFR 440.230).
- Comparability of services for groups. Services offered must be comparable for all categorically needy recipients and within each medically needy group (42 CFR 440.240). There are exceptions to this restriction. For example, certain services may be covered only for specific age groups.

The Secretary of the Department of Health and Human Services (DHHS) can waive these restrictions under certain circumstances. For example, a State could attempt to target home and community-based services to AIDS patients in a certain part of the State through this waiver authority.

Within the restrictions, States have the authority to place limits on covered services based on criteria such as utilization control or medical necessity (42 CFR 440.230). Examples of service limitations implemented by States as of March 1986 for inpatient services, physicians' services, and prescription drugs are shown in Table 4.7.

Thirteen States placed limits on the number of days of inpatient care covered, 12 States had a mandatory second surgical opinion program, and 20 States had an

Table 4.6
Medicaid services, by jurisdiction: October 1, 1989

Basic required Medicaid services

Medicaid recipients receiving federally supported financial assistance must receive at least these services:

- Inpatient hospital services.
- Outpatient hospital services.
- Rural health clinic services.
- Other laboratory and X-ray services.
- Skilled nursing facility services and home health services for individuals 21 or over.
- Early and periodic screening, diagnosis, and treatment for individuals under 21.
- Family planning services and supplies.
- Physician services.
- Nurse-midwife services.

Federal financial participation (FFP) is also available to States electing to expand their Medicaid programs by covering

Optional services in State Medicaid programs

FMAP[3]	• CN[1] + Both CN and MN[2] Basic required Medicaid services, see above		Podiatrists' services	Optometrists' services	Chiropractors' services	Other practitioners services	Private duty nursing	Clinic services	Dental services	Physical therapy	Occupational therapy	Speech, hearing, & language disorders	Prescribed drugs	Dentures	Prosthetic devices	Eyeglasses	Diagnostic services
73.21	•	Alabama		•				•		•			•		•	•	
50.00	•	Alaska		•	•			•	•	•	•	•			•	•	
50.00		American Samoa[4]					+	+	+	+	+	+	+	+	+	+	+
60.99	•	Arizona[5]	•	•			•	•	•	•	•	•	•	•	•	•	
74.58	+	Arkansas		+	+	+	+	+	+	+	+	+	+	+	+	+	
50.00	+	California	+	+	+	+		+	+	+	+	+	+	+	+	+	
52.11	•	Colorado	•	•		•	•	•					•		•	•	
50.00	+	Connecticut	+	+	+	+	+	+	+	+		+	+	+	+	+	+
50.00	•	Delaware	•	•		•	•	•					•		•		•
50.00	+	D.C.	+	+		+	+	+	+	+	+	+	+	+	+	+	+
54.70	+	Florida	+	+	+	+		+	+			+	+	+	+	+	
62.09	+	Georgia	+	+		+		+	+				+	+	+	+	
50.00	•	Guam		•				•	•			•	•			•	
54.50	+	Hawaii	+	+		+		+	+	+	+	+	+	+	+	+	+
73.32	•	Idaho	•	•	•	•		•		•			•				
50.00	+	Illinois	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
63.76	•	Indiana	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
62.52	+	Iowa	+	+	+	+		+	+	+	+	+	+	+	+	+	
56.07	+	Kansas	+	+	+	+		+	+	+	+	+	+	+	+	+	
72.95	+	Kentucky	+	+		+		+	+	+	+	+	+		+		+
73.12	+	Louisiana	•	+		•	+	+					+	+	+		
65.20	+	Maine	+	+	+	+	+		+	+	+	+	+	+	+	+	+
50.00	+	Maryland	+	+				+	+	+		+	+	+	+	+	
50.00	+	Massachusetts	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
54.54	+	Michigan	+	+	+	+		+	+	+	+	+	+	+	+	+	+
52.74	+	Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
80.18	•	Mississippi		•		•		•	•				•		•	•	
59.18	•	Missouri	•	•				•	•				•	•	•	•	
71.35	+	Montana	+	+		+	+	+	+	+	+	+	+	+	+	+	+
61.12	+	Nebraska	+	+	+	+	+	+	+	+		+	+	+	+	+	
50.00	•	Nevada	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
50.00	+	New Hampshire	+	+	+	+	+	+	+	+	+	+	+		+	+	+
50.00	+	New Jersey[7]	+	+	+	+		+	+	+	+	+	+	+	+	+	+
72.25	•	New Mexico	•	•		•		•	•	•			•	•	•	•	
50.00	+	New York	+	+		+	+	+	+	+	+	+	+	+	+	+	+
67.46	+	North Carolina	+	+	+		+	+	+				+	+		+	+
67.52	+	North Dakota	+	+	+		+	+	+	+	+	+	+	+	+	+	+
50.00	+	N. Mariana Islands[4]		+		+		+	+	+			+	+	+	+	
59.57	•	Ohio	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
68.29	+	Oklahoma	+	+		+		+	+				+		+	+	
62.95	+	Oregon	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
56.86	+	Pennsylvania	+	+	+			+	•				•	+	+	+	
50.00	+	Puerto Rico[6]						+									
55.15	+	Rhode Island	•	+					+				+	+	+	•	
73.07	•	South Carolina	•	•		•	•	•	•				•		•	•	
70.90	•	South Dakota			•			•	•	•		•	•	•	•		
69.64	+	Tennessee	+	+		+		+	+				+		+	+	
61.23	+	Texas[7]	+	+	+	+		+					+		+	+	
74.70	+	Utah	+	+		+	+	+	+	+		+	+	+	+	+	+
62.77	+	Vermont	+	+	+	+		+	+	+	+	+	+	+	+	+	
50.00	+	Virgin Islands[8]						+									
50.00	+	Virginia	+	+		+	+	+	+	+	+	+	+			+	
53.88	+	Washington	+	+	•	+	+	+	+	+	+	•	+	+	+	+	•
76.61	+	West Virginia	+	+	+	+	+	+	+	+		+	+	+	+	+	
59.28	+	Wisconsin		•	•	•	•	+	•	+	+	+	+	•	+	•	•
65.95	•	Wyoming		•				•		•			•		•		
•	16	•	12	16	8	11	8	16	13	10	5	8	16	8	14	14	4
+	39	+	32	36	21	30	20	38	34	29	23	28	37	31	36	34	18
	55	Total	44	52	29	41	28	54	47	39	28	36	53	39	50	48	22

[1]Categorically needy: Individuals receiving federally supported financial assistance.
[2]Medically needy: Individuals who are eligible for medical but not for financial assistance.
[3]Federal medical assistance percentage (FMAP): Rate of Federal financial participation in a State's Medical Assistance Program under title XIX of the Social Security Act. Effective October 1, 1989 throught September 30, 1990 (fiscal year 1990).
[4]American Samoa operates under a special Medicaid waivered program.

Table 4.6
Medicaid services, by jurisdiction: October 1, 1989

Basic required Medicaid services

additional services and/or by including people eligible for medical but not for financial assistance. For the latter group, States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Although States must assure the availability of necessary transportation, they may seek FFP either as an optional service or as an administrative cost.

Definitions and limitations on eligibility and services vary from State to State.

Details are available from local welfare offices and State Medicaid agencies.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under age 21 are not shown on this chart.

Optional services in State Medicaid programs

Screening services	Preventive services	Rehabilitative services	Age 65 or over in institutions for mental diseases: A. Inpatient hospital services	Age 65 or over in institutions for mental diseases: B. SNF services	Age 65 or over in institutions for mental diseases: C. ICF services	Intermediate care facility services	ICF for mentally retarded	Inpatient psychiatric services for under age 21	Christian Science nurses	Christian Science sanitoriums	SNF for under age 21	Emergency hospital services	Personal care services	Transportation services	Case management services	Hospital care services	Respiratory care services	Total additional services	
				•	•	•	•	•			•			•	•			14	AL
			•			•	•	•			•	•	•	•				17	AK
+	+	+										+		+				16	AS
						•	•				•	•	•	•		•	•	20	AZ
		+	+	•	•	•	•	+			•	+	•	+	+			25	AR
		+	+	+	+	+	+	+	+	+	+	+		+	+	+		27	CA
			•	•	•	•	•	•			•	•		•	•			18	CO
+	+	+	+	+	+	+	+	+		+	+			+				26	CT
		•	•		•	•	•				•	•		•		•		17	DE
+	+	+	+	+	+	+	+	+			+	+	+					26	DC
		+	•			•	•					+		+	+	+		19	FL
						+	+				+			+	+	+		15	GA
												•						7	GU
+	+	+				+	+	+			+	+		+		+		23	HI
		•			•	•	•				•	•		•		•		15	ID
	+	+	+	+	+	+	+	+		+	+	+		+		+		28	IL
•	•	•	•			•	•	•	•	•	•	•		•			•	28	IN
		•	•			•	•	•			•		•	+	+			22	IA
		+	+		+	+	+	+			+	+	+	+	+	+		25	KS
+	+	+	+	+	+	+	+	+			+	+		+	+	+		25	KY
		+	•			•	•	•			•			+	+			16	LA
+	+	+	+			+	+	+	+	+	+		+	+	+			27	ME
			+			+	+	+			+	+	+	+	+			19	MD
+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		32	MA
+		+	+	+	+	+	+	+		+	+	+	+	+	+	+	+	30	MI
+	+	+	+	+	+	+	+	+		+	+	+	+	+	+			30	MN
	•	•				•	•			•	•	•		•	•			16	MS
		•	•			•	•	•			•		•	•	•	•		18	MO
+	+	+	+	+	+	+	+	+			+	+	+	+		+		28	MT
			+	+	+	+	+	+			+	+	+	+	+			24	NE
		•	•	•	•	•	•				•	•	•	•			•	25	NV
+	+	+	+		+	+	+		+	+	+	+	+	+	+			28	NH
+	+	+	•	•	•	•	•	•		•	•	+	+	+				28	NJ
		•				•	•				•	•		•				16	NM
+	+	+	+			+	+	+			+	+	+	+	+	+	+	28	NY
+	+	+	+			+	+	+			+		+	+		+		21	NC
+	+	+	+			+	+	+			+	+		+		+		25	ND
												+		+				11	NMI
		•	•	•	•	•	•	•		•	•	•		•	•			26	OH
•		+	•			•	•	+			•		+	+	+			18	OK
	+	+	•			•	•	•		•	•	+	+	+			+	27	OR
			+	+	+	+	+	+			+	+		+	+	+		20	PA
																		1	PR
		+	+	+	+	+	+	+			+			+	+	+		18	RI
		•	•	•	•	•	•	•			•	•		•				19	SC
				•	•	•	•				•	•	•	•				16	SD
			•	•	+	+	•	+		+	+	+		+		+	+	20	TN
		+				+	+			+	+	+	+	+	+	+		18	TX
		+	+	+	•	•	•	+			+	+	+	+	+	+		26	UT
		+	+		+	+	+	+			+	+		+	+	+		24	VT
																		1	VI
		+	+	+	+	+	+			+	•	+		+	+			22	VA
	+	+	+	+	+	+	+	+			+	+		+	+		+	28	WA
						+	+	+			+	+	+	+	+		+	22	WV
•	•	•	•	+	+	+	+	•		+	+	•	+	+	•	+		30	WI
		•	•			•					•	•		•				11	WY
3	3	12	17	9	11	23	23	12	1	5	22	15	7	15	6	4	3		
15	17	29	24	16	19	28	27	26	4	12	28	29	19	37	25	20	6		
18	20	41	41	25	30	51	50	38	5	17	50	44	26	52	31	24	9		

[5]Arizona operates a Federal assistance program under a section 1115 demonstration project.
[6]All services are provided through public health facilities.
[7]Services indicated as available to the medically needy are not available to all medically needy groups.

NOTE: The data shown were supplied by individual Regional Offices and compiled by the Division of Intergovernment Affairs.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, Division of Intergovernmental Affairs.

Table 4.7

Selected limitations on selected Medicaid services, by State: March 1986

State	Inpatient hospital		
	Limit on number of covered days	Mandatory second surgical opinion program	Preadmission review program
Alabama	Y	N	N
Alaska	—	N	Y
Arizona	—	N	Y
Arkansas	Y	N	N
California	—	N	Y
Colorado	Y	Y	Y
Connecticut	—	N	N
Delaware	—	N	Y
District of Columbia	—	N	N
Florida	Y	N	Y
Georgia	—	N	N
Hawaii	—	N	Y
Idaho	Y	N	N
Illinois	—	N	N
Indiana	—	Y	Y
Iowa	—	N	N
Kansas	—	N	N
Kentucky	Y	N	Y
Louisiana	—	N	N
Maine	—	N	N
Maryland	Y	N	Y
Massachusetts	—	Y	N
Michigan	—	Y	Y
Minnesota	—	Y	N
Mississippi	Y	N	N
Missouri	—	Y	N
Montana	—	N	Y
Nebraska	—	N	N
Nevada	—	N	Y
New Hampshire	—	N	N
New Jersey	—	Y	N
New Mexico	—	N	N
New York	—	N	N
North Carolina	—	N	N
North Dakota	—	N	Y
Ohio	—	N	N
Oklahoma	—	N	N
Oregon	Y	Y	Y
Pennsylvania	—	N	N
Rhode Island	—	N	Y
South Carolina	—	N	Y
South Dakota	—	N	N
Tenessee	Y	Y	N
Texas	Y	N	N
Utah	—	N	N
Vermont	—	N	Y
Virginia	Y	Y	N
Washington	—	Y	Y
West Virginia	Y	N	N
Wisconsin	—	Y	Y
Wyoming	—	N	N

See footnotes at end of table.

Table 4.7—Continued

Selected limitations on selected Medicaid services, by State: March 1986

State	Limit on number of physician visits		
	Inpatient hospital	Long-term care facility	Office
Alabama	Y	—	—
Alaska	—	—	—
Arizona	—	—	—
Arkansas	—	Y	Y
California	—	—	—
Colorado	—	—	—
Connecticut	—	Y	—
Delaware	—	—	—
District of Columbia	—	—	—
Florida	Y	Y	—
Georgia	Y	Y	—
Hawaii	—	Y	—
Idaho	—	—	—
Illinois	—	—	—
Indiana	—	—	—
Iowa	—	—	—
Kansas	—	—	Y
Kentucky	—	—	—
Louisiana	—	—	—
Maine	—	—	—
Maryland	—	—	—
Massachusetts	—	—	—
Michigan	—	Y	—
Minnesota	—	—	—
Mississippi	Y	Y	—
Missouri	—	—	—
Montana	—	—	—
Nebraska	—	—	—
Nevada	—	—	Y
New Hampshire	Y	—	—
New Jersey	—	—	—
New Mexico	Y	—	—
New York	—	—	—
North Carolina	—	—	—
North Dakota	—	—	—
Ohio	Y	Y	—
Oklahoma	Y	Y	Y
Oregon	—	—	—
Pennsylvania	—	—	—
Rhode Island	Y	—	—
South Carolina	—	—	—
South Dakota	—	—	—
Tennessee	—	—	Y
Texas	—	—	—
Utah	—	—	—
Vermont	—	Y	—
Virginia	Y	—	—
Washington	Y	Y	—
West Virginia	—	—	—
Wisconsin	—	—	—
Wyoming	—	Y	—

See footnotes at end of table.

Table 4.7—Continued

Selected limitations on selected Medicaid services, by State: March 1986

State	Limit on prescription drugs	
	Quantity of single prescription	Number of refills
Alabama	Y	Y
Alaska	N	N
Arizona	—	—
Arkansas	Y	Y
California	Y	N
Colorado	Y	N
Connecticut	Y	N
Delaware	N	N
District of Columbia	Y	Y
Florida	N	N
Georgia	Y	N
Hawaii	Y	N
Idaho	Y	N
Illinois	N	N
Indiana	N	N
Iowa	N	N
Kansas	Y	N
Kentucky	N	Y
Louisiana	Y	Y
Maine	Y	Y
Maryland	Y	Y
Massachusetts	N	N
Michigan	Y	Y
Minnesota	Y	Y
Mississippi	N	Y
Missouri	Y	Y
Montana	N	N
Nebraska	N	N
Nevada	Y	Y
New Hampshire	Y	Y
New Jersey	Y	Y
New Mexico	N	Y
New York	N	Y
North Carolina	N	Y
North Dakota	N	Y
Ohio	Y	Y
Oklahoma	Y	Y
Oregon	Y	Y
Pennsylvania	Y	Y
Rhode Island	Y	Y
South Carolina	Y	N
South Dakota	N	N
Tennessee	Y	Y
Texas	Y	Y
Utah	N	N
Vermont	Y	Y
Virginia	N	N
Washington	Y	N
West Virginia	Y	Y
Wisconsin	Y	Y
Wyoming	N	N

NOTES: Y is yes; N is no. Limits were placed on the number of covered days of inpatient care by 13 States, 12 States had a mandatory second surgical opinion program, and 20 States had an inpatient hospital preadmission review program. The number of covered physician visits was limited in an inpatient hospital by 11 States, in a long-term care facility by 12 States, and in an office by 5 States. Limits were placed on the quantity of any single prescription drug by 31 States, and limits were placed on the number of refills within a certain time period by 27 States.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Estimates and Statistics.

inpatient hospital preadmission review program. A number of States limited the number of covered physician visits in an inpatient hospital (11 States), long-term-care facility (12 States), or office (5 States). Examples of controls on the utilization of prescription drugs included placing limits on the quantity of any single prescription (31 States), and placing limits on the number of refills in a certain time period (28 States).

For more information on service limitations under Medicaid see Health Care Financing Administration (1987). For more information on Medicaid waivers, see Congressional Research Service (1988).

Administration and financing

Information on the administration and financing of the Medicaid program is presented in this section. It begins by discussing methods used by the States to reimburse providers for services rendered to Medicaid recipients. Next, it discusses how the vendor payments and administrative costs of the Medicaid program are financed. Finally, it outlines the general administrative structure of the program.

Methods of provider reimbursement

Medicaid is a vendor payment program because payments are made directly to providers for services rendered to eligible individuals. Providers who choose to participate in the program must accept the Medicaid reimbursement as full payment.

States have wide latitude in choosing methods of provider reimbursement. Reimbursement methods used by States for inpatient hospital services, long-term-care facility services (including SNF and ICF services), physicians' services, outpatient services, and prescription drugs are discussed in this section. These services cover a large share of the total payments made under Medicaid. A general classification of methods used by the States to determine reimbursement levels for these services is shown in Table 4.8. The section concludes with a brief description of prepaid risk contracts under Medicaid.

Methods used by the States to reimburse for inpatient hospital services can be divided into two broad categories—retrospective cost-based methods and prospective methods. In a retrospective system, payments are determined after services are rendered and are based on the actual costs incurred by the provider in furnishing those services. In 1989, nine States used some form of retrospective cost-based method for hospital reimbursement.

In a prospective system, payment amounts are determined in advance. The provider receives a specific rate for each service rendered, regardless of whether the provider's actual costs were more or less than that rate. Prospective methods used in Medicaid can be divided into three subcategories: rate-of-increase control systems, case-mix systems, and negotiated systems.

In a rate-of-increase control system, the provider is paid a fixed rate per day or per case. This rate is typically based on the hospital's average costs in a base

year adjusted for inflation. Most States using this method also impose a ceiling on the rates based on factors such as type of hospital or location. As of January 1989, 21 States used some form of prospective rate-of-increase-control method for inpatient hospital reimbursement.

In a prospective case-mix system, the reimbursement rate for services to a particular patient is based on the diagnosis. Each case is classified into one of a set of diagnosis-related groups (DRGs). Each DRG is assigned a weighting factor that measures the relative resources required by a typical patient with a given condition, as compared with all patients. A payment is made for each case in a given DRG by multiplying the weighting factor for the DRG by a predetermined rate. The predetermined rate may vary by hospital or class or facility (defined by factors such as size or location). As of January 1989, 17 States used some form of a prospective case-mix system for hospital reimbursement.

In a negotiated system, the State uses a competitive bid or negotiation process to select certain providers who can provide services to Medicaid recipients. Except in emergency cases, Medicaid patients are required to obtain inpatient services from the selected providers. Payment rates for services are established in the bidding or negotiation process. States choosing this option typically obtain waivers of the "freedom of choice" requirements (see Service coverage and limitations section) through section 2175 of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (Public Law 97-35). As of January 1989, 4 States used some form of negotiated system for inpatient hospital reimbursement.

Whatever reimbursement method the State chooses, Federal regulations stipulate that aggregate payments for inpatient hospital services cannot exceed what would have been paid had Medicare's prospective case-mix principles of hospital reimbursement been used.

Reimbursement methods used by States for long-term-care services (including services provided in SNFs and ICFs) also can be divided broadly into retrospective cost-based methods and prospective methods. In fiscal year 1987, 7 States used some form of cost-based system for SNFs and 43 States used prospective methods. Aggregate payments for SNF services cannot exceed what would have been spent had Medicare's retrospective cost method been used. Five States reimbursed for ICF services using a retrospective method, while 45 used prospective methods.

Methods used by the States for physician reimbursement can be broken roughly into two broad categories—customary, prevailing, and reasonable charge (CPR) methodology or fee schedules. States choosing CPR methods typically limit reimbursements for physicians' services to the lowest of: the physician's actual charge; the physician's customary charge for comparable services (for example, the physician's median charge in a recent prior period); or the prevailing charge in the area (for example, the 75th percentile of the customary charges of all providers in the area). In fiscal year 1987, 19 States used some form of the CPR method to reimburse for physicians' services. States choosing fee schedules specify a flat maximum payment for each service. Four States used some form of relative-value scale to set the fee schedule. In a relative-value scale, each service is given a specific weight based on the "relative value" of the service. This relative value, for example, may be based on an assessment of resource cost of the service (physician time, complexity, level of training required, etc.). The specific weight for the service is multiplied by a standard dollar amount to arrive at the fee for the service. Twenty-seven States determined the fee schedules on other bases (they are simply referred to as fixed-fee States in Table 4.8).

A large number of methods are employed by the States to reimbursement providers for services rendered in outpatient departments of hospitals. For simplicity, these methods have been categorized as retrospective cost-based methods and other methods. States choosing retrospective methods reimburse providers for reasonable costs incurred for the service. As of January 1989, 29 States used some form of retrospective cost-based reimbursement for outpatient services. The remaining States used a variety of other reimbursement methods for outpatient services, including prospective methods, fee schedules, and negotiated rates. Federal regulations specify that aggregate payments for outpatient services may not exceed what would have been paid had Medicare's retrospective cost-based methodology been used.

As of fiscal 1990, Federal regulations impose two limits that shape State reimbursement policy for prescription drugs. The first limit applies to multiple source drugs (i.e., drugs for which therapeutically equivalent "generic" versions exist). For each of these drugs, a cost limit is established at 150 percent of the cost of the least expensive equivalent drug. The State's total payments for all multiple source drugs may not exceed what would have been paid using the cost limits, plus a reasonable dispensing fee. This limit provides an incentive for generic substitution. The second limit applies to all other drugs. The total cost of these drugs cannot exceed the lesser of the State's estimated acquisition costs plus a reasonable dispensing fee or the providers' usual and customary charges to the general public. The estimated acquisition cost represents the amount pharmacies pay for drug ingredients and is an amount lower than published wholesale prices. Within these limits, States can set reimbursement levels for individual drugs and types of providers as they see fit.

The methods discussed previously pertain to fee-for-service reimbursement methods. States also may enter into risk contracts with health maintenance organizations (HMOs) or comparable entities. Under a risk contract, the organization agrees to provide a specific set of services to a Medicaid enrollee in return for a fixed periodic payment. The periodic payment is referred to as a capitation payment or premium. For example, the organization may agree to provide access to all necessary inpatient hospital, physician, and laboratory and X-ray services to Medicaid enrollees in the plan for a fixed, monthly premium paid by the State. As of December 1987, there were 189 capitated plans in 29 States serving approximately 2.3 million Medicaid enrollees (Health Care Financing Administration, Office of Prepaid Health Care, 1988).

Table 4.8

Medicaid provider reimbursement methods, by State[1]

State	Inpatient hospital			
		Prospective		
	Retrospective cost-based	Rate-of-increase controls	Case mix	Negotiated
Alabama		X		
Alaska		X		
Arizona				X
Arkansas		X		
California				[2]X
Colorado			[3]X	
Connecticut	X			
Delaware	X			
District of Columbia		X		
Florida		X		
Georgia		X		
Hawaii		X		
Idaho	X			
Illinois				[2]X
Indiana	X			
Iowa			X	
Kansas		X		
Kentucky		X		
Louisiana	X			
Maine	X			
Maryland			[2]X	
Massachusetts		X		
Michigan			X	
Minnesota			X	
Mississippi		X		
Missouri		X		
Montana			X	
Nebraska		X		
Nevada		X		
New Hampshire	X			
New Jersey			X	
New Mexico		[2]X		
New York			X	
North Carolina		X		
North Dakota			X	
Ohio			X	
Oklahoma		X		
Oregon			X	
Pennsylvania			X	
Rhode Island				X
South Carolina			X	
South Dakota			[2]X	
Tennessee		X		
Texas			X	
Utah			[2]X	
Vermont		X		
Virginia		X		
Washington			[2]X	
West Virginia	X			
Wisconsin		X		
Wyoming	X			

See footnotes at end of table.

Table 4.8—Continued

Medicaid provider reimbursement methods, by State[1]

State	Skilled nursing facilities	
	Retrospective cost-based	Prospective
Alabama		X
Alaska		X
Arizona	—	—
Arkansas		X
California		X
Colorado		X
Connecticut		X
Delaware		[4]X
District of Columbia		X
Florida		X
Georgia		X
Hawaii		X
Idaho	X	
Illinois		X
Indiana		X
Iowa		X
Kansas		X
Kentucky		X
Louisiana		X
Maine	X	
Maryland		X
Massachusetts		X
Michigan		X
Minnesota		X
Mississippi		X
Missouri		X
Montana		X
Nebraska		X
Nevada		X
New Hampshire	X	
New Jersey		X
New Mexico		X
New York		X
North Carolina		X
North Dakota		X
Ohio	X	
Oklahoma		X
Oregon	X	
Pennsylvania	X	
Rhode Island		X
South Carolina		X
South Dakota		X
Tennessee	X	
Texas		X
Utah		X
Vermont		X
Virginia		X
Washington		X
West Virginia		X
Wisconsin		X
Wyoming		X

See footnotes at end of table.

Table 4.8—Continued

Medicaid provider reimbursement methods, by State[1]

State	Intermediate care facilities[5]	
	Retrospective cost-based	Prospective
Alabama		X
Alaska		X
Arizona	—	—
Arkansas		X
California		X
Colorado		X
Connecticut		X
Delaware		[4]X
District of Columbia		X
Florida		X
Georgia		X
Hawaii		X
Idaho	X	
Illinois		X
Indiana		X
Iowa		X
Kansas		X
Kentucky		X
Louisiana		X
Maine		X
Maryland		X
Massachusetts		X
Michigan		X
Minnesota		X
Mississippi		X
Missouri		X
Montana		X
Nebraska		X
Nevada		X
New Hampshire		X
New Jersey		X
New Mexico		X
New York		X
North Carolina		X
North Dakota		X
Ohio	X	
Oklahoma		X
Oregon	X	
Pennsylvania	X	
Rhode Island		X
South Carolina		X
South Dakota		X
Tennessee	X	
Texas		X
Utah		X
Vermont		X
Virginia		X
Washington		X
West Virginia		X
Wisconsin		X
Wyoming		X

See footnotes at end of table.

Table 4.8—Continued

Medicaid provider reimbursement methods, by State[1]

State	Physician		
		Fee schedule	
	CPR[6]	Fixed	Relative-value scale
Alabama	X		
Alaska	X		
Arizona	—	—	—
Arkansas		X	
California			X
Colorado			X
Connecticut		X	
Delaware		X	
District of Columbia		X	
Florida		X	
Georgia		X	
Hawaii	X		
Idaho			X
Illinois		X	
Indiana	X		
Iowa	X		
Kansas	X		
Kentucky	X		
Louisiana	X		
Maine		X	
Maryland		X	
Massachusetts		X	
Michigan		X	
Minnesota	X		
Mississippi		X	
Missouri		X	
Montana		X	
Nebraska	X		
Nevada		X	
New Hampshire		X	
New Jersey		X	
New Mexico	X		
New York		X	
North Carolina	X		
North Dakota	X		
Ohio		X	
Oklahoma	X		
Oregon		X	
Pennsylvania		X	
Rhode Island		X	
South Carolina			X
South Dakota	X		
Tennessee	X		
Texas	X		
Utah		X	
Vermont		X	
Virginia		X	
Washington		X	
West Virginia		X	
Wisconsin	X		
Wyoming	X		

See footnotes at end of table.

Table 4.8—Continued

Medicaid provider reimbursement methods, by State[1]

State	Outpatient	
	Retrospective cost-based	Other
Alabama		X
Alaska		X
Arizona		X
Arkansas		X
California		X
Colorado	X	
Connecticut		X
Delaware	X	
District of Columbia		X
Florida		X
Georgia	X	
Hawaii		X
Idaho	X	
Illinois		X
Indiana	X	
Iowa	X	
Kansas		X
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland		X
Massachusetts		X
Michigan	X	
Minnesota	X	
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska	X	
Nevada		X
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York		X
North Carolina	X	
North Dakota	X	
Ohio	X	
Oklahoma		X
Oregon	X	
Pennsylvania		X
Rhode Island		X
South Carolina		X
South Dakota	X	
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington		X
West Virginia		X
Wisconsin		X
Wyoming	X	

See footnotes at end of table.

Table 4.8—Continued

Medicaid provider reimbursement methods, by State[1]

[1] Data for inpatient hospital and outpatient services are as of January 1989. Other data are for fiscal year 1987.
[2] Not all hospitals in the State are under this reimbursement system. See Intergovernmental Health Policy Project (1989) for details.
[3] Not yet formally approved by the Health Care Financing Administration.
[4] Private facilities are under a prospective system, but public facilities are under a retrospective cost-based system.
[5] Does not include intermediate care facilities for the mentally retarded.
[6] Customary, prevailing, and reasonable charge method.

NOTES: For inpatient hospital reimbursement, 9 States used some form of retrospective cost-based method, 21 States used some form of prospective rate-of-increase control method, 17 States used some form of case-mix system, and 4 States used some form of negotiated system. For skilled nursing facility, 7 States used some form of retrospective cost-based system, and 43 States used prospective methods. For intermediate care facility, 5 States used a retrospective cost-based method, and 45 States used prospective methods. For physician reimbursement, 19 States used some form of CPR method, 4 States used some form of relative-value scale, and 27 States determined the fee schedules on other bases (they are simply referred to as fixed-fee States). For outpatient services, 29 States used some form of retrospective cost-based method, and the remaining States used a variety of other methods including prospective methods, fee schedules, and negotiated rates.

SOURCES: Data for inpatient hospital and outpatient services: Intergovernmental Health Policy Project: *State Systems for Hospital Payment.* Contract No.T-56951792. Prepared for the Prospective Payment Assessment Commission. Washington. Apr. 1989. Other data: (Congressional Research Service, 1988).

This section on methods of provider reimbursement in Medicaid drew heavily from Congressional Research Service (1988). For more detailed discussion of these topics, see that publication.

Financing

The costs of the Medicaid program are financed jointly by the Federal Government and the States. Federal and State participation in Medicaid financing is discussed in this section. Next, coordination between the Medicaid and the Medicare programs is described. A brief description of other issues in Medicaid financing, including other third-party liability and cost sharing in Medicaid, follows.

Federal participation in Medicaid financing

The Federal government contributes to the financing of the Medicaid program through percentage payments. The Federal Government makes payments to the States for services rendered to Medicaid recipients on the basis of the Federal medical assistance percentage (FMAP). The formula for determining FMAP values is established by statute (42 CFR 433.10), and is calculated as follows:

$$\text{FMAP} = 100 \text{ percent} - \text{State share}$$

$$\text{State share} = \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \times 45 \text{ percent}$$

By design, the formula sets higher rates of Federal funding for States with relatively low per capita incomes and lower rates for States with relatively high per capita incomes. Federal statute limits FMAP values to a maximum of 83 percent and a minimum of 50 percent.

The FMAP values in effect for fiscal years 1980-90 are shown in Table 4.9. No State received the maximum Federal funding in 1990 (Mississippi received the highest percentage at 80.18 percent), while 16 jurisdictions received the minimum of 50 percent.

The rate for the territories is set at 50 percent with limits on the total Federal dollar amount

Table 4.9

Federal medical assistance percentages, by jurisdiction: Fiscal years 1980-90

Medicaid jurisdiction	1980-81	1982-83	1984-85	1986	1987	1988	1989	1990
Alabama	71.32	71.13	72.14	72.30	72.41	73.29	73.10	73.21
Alaska	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Arizona	61.47	59.87	61.21	62.28	62.13	62.12	62.04	60.99
Arkansas	72.87	72.16	73.65	73.83	74.02	74.21	74.14	74.58
California	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Colorado	53.16	52.28	50.00	50.00	50.00	50.00	50.00	52.11
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Delaware	50.00	50.00	50.00	50.00	50.00	51.90	52.60	50.00
District of Columbia	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Florida	58.94	57.92	58.41	56.16	55.54	55.39	55.18	54.70
Georgia	66.76	66.28	67.43	66.05	64.54	63.84	62.78	62.09
Guam	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Hawaii	50.00	50.00	50.00	51.00	51.29	53.71	53.99	54.50
Idaho	65.70	65.40	67.28	69.36	71.08	70.47	72.71	73.32
Illinois	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Indiana	57.28	56.73	59.93	62.82	62.92	63.71	63.71	63.76
Iowa	56.57	55.35	55.24	58.90	60.39	62.75	62.95	62.52
Kansas	53.52	52.50	50.67	50.00	51.39	55.20	54.93	56.07
Kentucky	68.07	67.95	70.72	70.23	70.75	72.27	72.89	72.95
Louisiana	68.82	66.85	64.45	63.81	65.77	68.26	71.07	73.12
Maine	69.53	70.63	70.63	68.86	68.07	67.08	66.68	65.20
Maryland	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Massachusetts	51.75	53.56	50.13	50.00	50.00	50.00	50.00	50.00
Michigan	50.00	50.00	50.70	56.79	56.88	56.48	54.75	54.54
Minnesota	55.64	54.39	52.67	53.41	52.98	53.98	53.07	52.74
Mississippi	77.55	77.36	77.63	78.42	78.50	79.65	79.80	80.18
Missouri	60.36	60.38	61.40	60.62	59.85	59.27	59.96	59.18
Montana	64.28	65.34	64.41	66.38	67.44	69.40	70.62	71.35
Nebraska	57.62	58.12	57.13	57.11	58.06	59.73	60.37	61.12
Nevada	50.00	50.00	50.00	50.00	50.00	50.25	50.00	50.00
New Hampshire	61.11	59.41	59.45	54.92	53.28	50.00	50.00	50.00
New Jersey	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Mexico	69.03	67.19	69.39	68.94	69.68	71.52	71.54	72.25
New York	50.00	50.88	50.00	50.00	50.00	50.00	50.00	50.00
North Carolina	67.64	67.81	69.54	69.18	68.40	68.68	68.01	67.46
North Dakota	61.44	62.11	61.32	55.12	56.41	64.87	66.53	67.52
Ohio	55.10	55.10	55.44	58.30	58.27	59.10	58.98	59.57
Oklahoma	63.64	59.91	58.47	57.60	59.86	63.33	66.06	68.29
Oregon	55.66	52.81	57.12	61.54	62.47	62.11	62.44	62.95
Pennsylvania	55.14	56.78	56.04	56.72	57.28	57.35	57.42	56.86
Puerto Rico	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Rhode Island	57.81	57.77	58.17	56.33	55.38	54.85	55.88	55.15
South Carolina	70.97	70.77	73.51	72.70	72.23	73.49	73.08	73.07
South Dakota	68.78	68.19	68.31	67.82	67.45	70.43	71.02	70.90
Tennessee	69.43	68.53	70.66	70.20	70.26	70.64	70.17	69.64
Texas	58.35	55.75	54.37	53.56	55.16	56.91	59.04	61.23
Utah	68.07	68.64	70.84	72.62	73.21	73.73	73.86	74.70
Vermont	68.40	69.37	68.59	67.06	67.37	66.23	63.92	62.77
Virgin Islands	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Virginia	56.54	56.74	56.53	53.14	51.86	51.34	51.20	50.00
Washington	50.00	50.00	50.00	50.06	52.52	53.21	53.06	53.88
West Virginia	67.35	67.95	70.57	71.53	72.59	74.84	76.14	76.61
Wisconsin	57.95	58.02	56.87	57.54	57.58	58.98	59.31	59.28
Wyoming	50.00	50.00	50.00	50.00	54.20	57.96	62.61	65.95

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of State Agency Financial Management.

(42 CFR 433.10[b]). The limits in effect for fiscal year 1988 were as follows: American Samoa, $1,330,000; Guam, $2,320,000; Northern Marianas, $636,700; Puerto Rico, $73,400,000; and Virgin Islands, $2,430,000.

By special provision, the Federal assistance percentage for family planning services is set at 90 percent (42 CFR 433.10[c]).

FMAP values pertain only to Federal funding for medical vendor payments. The Federal Government also provides assistance payments for administrative costs of the program as follows (42 CFR 433.15):

- Administration of family planning services is funded at 90 percent.
- Design, development, or installation of mechanized claims processing and information retrieval systems is funded at 90 percent, and the operation of such systems is funded at 75 percent.
- Compensation and training of skilled professional and medical personnel and staff directly supporting those personnel is funded at 75 percent.
- The performance of medical and utilization review by a peer review organization is funded at 75 percent.
- State Medicaid fraud and abuse units located organizationally outside of the single State agency are funded at 90 percent for the first 3 years of their operation and at 75 percent thereafter.
- All other activities the Secretary finds necessary for proper and efficient administration of the program are funded at 50 percent.

State participation in Medicaid financing

State participation in Medicaid financing includes the non-Federal portion of medical vendor payments and the non-Federal portion of program administrative costs.

The non-Federal share of medical vendor payments may be provided from State or local revenues. The State must ensure that it bears at least 40 percent of the non-Federal share, and it must guarantee that a lack of local funds will not result in reduced amounts, duration, scope, or quality of care provided to Medicaid recipients. As of March 1986, 14 States provided for local funding of the non-Federal share of medical vendor payments. The local funding formulas that were in effect are presented in Table 4.10.

The State also is responsible for the total costs of services to State-only eligibles and for any additional services offered by the State that do not qualify for Federal financial participation (FFP).

Coordination with the Medicare program

Many aged and disabled Medicaid enrollees are also eligible for Medicare. Since Medicaid is the payer of last resort, Medicare-covered services provided to these dually enrolled individuals may be financed by the Medicare program rather than Medicaid.

Recall that Medicare coverage is divided into two parts: Part A, hospital insurance (HI), including coverage of inpatient hospital, SNF, hospice, and some home health services; and Part B, supplementary medical insurance (SMI), including coverage of physician, hospital outpatient, home health care, and a variety of ancillary services. Part A coverage is automatic for all persons entitled to Medicare benefits (see Chapter 3), but Part B is optional and is obtained through an enrollee-paid premium.

Table 4.10

Local funding formulas for Medicaid vendor payments, by State: March 1986

State	Formula
Colorado	20 largest counties pay 2 percent of State share for all new ICF admissions.
Florida	Counties pay: 35 percent of cost or $55.00 per month, whichever is less, for each nursing home resident; 35 percent of cost for 13th-45th inpatient hospital day.
Iowa	Counties match Federal funds for ICFs/MR.
Minnesota	Counties pay 10 percent of State share.
Montana	Counties pay 18 percent of eligibility personnel costs.
Nebraska	Counties pay 5 percent of total expenditures.
New Hampshire	Local contribution of appproximately 25 percent of nursing home costs, excluding residents in State institutions.
New York	Counties pay 50 percent of non-Federal share except for long-term care, for which they pay 20 percent of non-Federal share.
North Carolina	Counties pay 15 percent of non-Federal share for all services.
North Dakota	Counties pay 15 percent of State share except for ICFs/MR, clinic services, and waivered home and community-based services for mentally retarded, aged, and disabled recipients.
Pennsylvania	Counties pay 10 percent of State share for county nursing homes plus $3 per invoice administration fee.
South Dakota	Local contribution of $60.00 per month for each ICF/MR resident and local school district for Crippled Children's Hospital.
Utah	Local contribution of less than 1 percent for specific services (e.g., mental health).
Wisconsin	Local contribution of 10-20 percent for mental health services.

NOTE: ICF is intermediate care facility. ICF/MR is intermediate care facility for the mentally retarded.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

For the dually enrolled population, Medicaid pays only coinsurance and deductible payments for Medicare Part A covered services. States have the option to "buy in" for Part B coverage by paying the SMI premium for the dually enrolled (States also can buy in for Part A coverage). In States that choose to buy in for part B coverage, the Medicaid program is responsible only for the SMI premium, coinsurance, and deductible payments for Medicare Part B covered services. If a State chooses not to buy in for Part B coverage for the dually enrolled, it does not receive Federal assistance payments for services that would have been covered under SMI. As of 1989, only Puerto Rico and the Northern Marianas did not have buy-in agreements for Part B coverage. The forthcoming section on Medicaid program data will present information on the number of Medicaid eligibles enrolled as Medicare buy-ins.

The payments made by the Medicaid program for Medicare premiums, coinsurance, and deductibles generally are divided between the Federal Government and the State based on the Federal assistance percentage. There are exceptions, however. For example, Part B premiums for the medically needy are paid entirely by the State.

Other issues in Medicaid financing

In some circumstances, services provided to Medicaid recipients may be covered by other sources (e.g., hospital services required by a Medicaid recipient because of an automobile accident may be covered by another driver's automobile insurance). Since Medicaid is the payer of last resort, States are required to pursue such other third-party liability. There are two basic options for dealing with third-party liability. First, the State can deny reimbursement for the service and instruct the provider to bill the third party (cost avoidance method). Second, the State can choose to pay the claim and then seek reimbursement itself from the third party (pay and chase method). Health Care Financing Administration (HCFA) regulations generally require cost avoidance, but provide some exceptions where the pay and chase method may be used. HCFA estimates that roughly $1.4 billion was avoided or reclaimed through third-party liability in fiscal year 1988 (Health Care Financing Administration, 1988a).

States are also permitted to require Medicaid recipients to share some of the costs of services they receive by imposing nominal deductibles and copayments (42 CFR 447.50). States may *not* impose cost sharing on the following:

- Services furnished to individuals under 18 years of age (or up to 21 years of age at State option).
- Pregnancy-related services.
- Services provided to certain institutionalized persons who are required to spend all of their income (except for a personal needs allowance) for medical care.
- Emergency services.
- Family planning services and supplies.
- Services provided to categorically needy HMO enrollees.

In addition, not more than one type of charge can be imposed on any service. State cost-sharing policies in effect in March 1986 can be found in Health Care Financing Administration (1987).

Administrative structure

The Medicaid program is administered by State agencies with general oversight from HCFA. Each State must designate a single agency that is responsible for program operations. The agencies responsible for Medicaid in each State are presented in Appendix B. As noted by Congressional Research Service (1988), the basic administrative functions that must be fulfilled by the State agency responsible for Medicaid include the following:

- Eligibility determination. The agency must determine which individuals are eligible to receive services.
- Provider certification. The agency must develop agreements with providers in order to qualify them to receive Medicaid payments. Federal law provides standards and certification procedures for institutional providers such as hospitals and nursing facilities. State certification agencies, which are different from Medicaid agencies, perform the survey and certification process for such institutional providers. States generally apply their own standards for licensure for noninstitutional providers such as physicians—they generally rely on the determinations of an applicable State licensing board.
- Claims processing. The agency is responsible for processing claims submitted by providers for services rendered to Medicaid recipients. The State agency may process the claims or it may use a fiscal agent to perform this task. As of March 1986, 16 States processed their own inpatient, physician, and dental claims, 17 processed their own prescription drug claims, and 21 processed long-term-care facility claims. In the remaining States, fiscal agents or health insuring organizations processed the claims, either totally or in conjunction with the State. See Health Care Financing Administration (1987) for the specific State breakdowns.
- Program control. This function generally involves three activities designed to ensure that the program is properly administered. First, the agency is responsible for maintaining quality control systems, which monitor certain aspects of its administrative performance, particularly focusing on errors in eligibility determination and claims processing. For functions under review, the State selects a monthly sample of cases for review and estimates an error rate. Federal staff select a subsample and also develop an error rate. An overall error rate is developed using State and Federal findings. If the error rate exceeds certain levels, Federal payments may be reduced. Second, the agency is responsible for producing information on program utilization and expenditures and for producing reports required by HCFA. Third, the agency must have procedures for reviewing the adequacy and appropriateness of the services delivered to Medicaid recipients. For

example, the agency is responsible for conducting inspections of care at inpatient facilities in which an inspection team reviews the records of selected Medicaid recipients to assess whether the care provided is adequate and appropriate.

- Program integrity. The agency must have in place a system for identifying and investigating potential cases of fraud and abuse. The State typically utilizes a part of its claims processing and payment operation to help identify such cases. It examines patterns of utilization from Medicaid claims to identify unusual providers or recipients. Cases of apparent abuse are often handled by the Medicaid agency through reeducation or sanction of the offending provider or recipient. Possible cases of fraud can be referred to Medicaid fraud control units, operated outside the Medicaid agency, which are responsible for investigating and prosecuting such cases.

Medicaid program data

Basic program data on Medicaid are presented in this section. First presented are data on patterns of utilization in Medicaid, followed by data on Medicaid payments. The section concludes with a brief presentation of data on provider participation in the Medicaid program.

Medicaid utilization

Utilization information is presented for the Medicaid population by eligibility category and demographic group, service category, and for selected other characteristics. Medicaid recipient and service statistics are not presented as rates per 1,000 eligibles (population at risk), as are the Medicare data presented in Chapter 3. Instead, the data present proportions of those who actually receive services. No national counts of the number of Medicaid eligibles are available at present.

Utilization by eligibility category and demographic group

The number and percent of Medicaid recipients are presented by eligibility category and jurisdiction and ranked by number of recipients in fiscal year 1986 (Table 4.11). The eligibility categories shown are the aged, blind, disabled, low-income families with dependent children, and other title XIX groups. There was a total of 22.5 million recipients of Medicaid services in fiscal year 1986. Of these, 69.6 percent were from low-income families with dependent children, 14.2 percent were blind or disabled, 13.9 percent were aged, and 6.1 percent were from other title XIX groups. Note that the sum of percentages by eligibility category may exceed 100 percent because a recipient may be counted in more than one eligibility group but is counted only once in the total. Seven jurisdictions accounted for more than half of all Medicaid recipients (California, New York, Puerto Rico, Michigan, Pennsylvania, Ohio, and Illinois).

The number and percent distribution of Medicaid recipients by maintenance assistance status and basis of eligibility are shown in Table 4.12. Two maintenance assistance categories are identified. Individuals in the "cash assistance" category received cash assistance for their basic necessities through public assistance programs (e.g., AFDC or SSI); individuals in the "medical assistance only" category did not. The medical assistance only group includes the categorically needy who did not receive cash assistance and the medically needy. In fiscal year 1986, 71.4 percent of all Medicaid recipients received cash assistance and 28.6 percent received medical assistance only. Note that the aged are substantially more likely than the other eligibility groups to receive medical assistance only (other title XIX groups could only be in the medical assistance only category).

The percent of Medicaid recipients by age, sex, race or ethnic origin, and jurisdiction are presented in Table 4.13. More than half of all Medicaid recipients in fiscal year 1986 were under 21 years of age, 33.5 percent were 21-64 years of age, and 16.2 percent were 65 years of age or over. Females accounted for 64 percent of all Medicaid recipients. More than 54 percent of Medicaid recipients were white, 29.0 percent were black, 10.1 percent were Hispanic, and 6.4 percent were of other races or ethnic origins. The race or ethnic origin of significant numbers of recipients in some reporting States was unknown. HCFA's Bureau of Data Management and Strategy estimated the number of recipients by race or ethnic origin for these States. Therefore, the data by race should be used with caution.

Utilization by type of service

The percent of Medicaid recipients using various medical services, by jurisdiction, are shown in Table 4.14. Recipient counts for each type of service are unduplicated, so recipients who receive a given service more than one time are counted only once. For example, a recipient who had two inpatient hospital admissions during the year would be counted only once in the inpatient recipient total. In addition, recipients may have received more than one type of service. For example, the same recipient may have used inpatient hospital services, physicians' services, and outpatient hospital services. This person would be included in the recipient count for each service. Thus the sum of the percentages across types of service exceeds 100 percent.

Services used by most recipients include physicians' services (66.2 percent), prescription drugs (65.3 percent), and outpatient hospital services (47.6 percent). Less than 16 percent of the 22.5 million Medicaid recipients used inpatient general hospital services, 2.5 percent used SNF services, 3.7 percent used ICF services, and only 0.6 percent used ICF/MR services. As will be seen later, these latter four service categories account for a large portion of Medicaid payments.

The number and percent of Medicaid recipients using specified types of medical service by age, sex, and race or ethnic origin are presented in Table 4.15. Persons

Table 4.11

Number and percent distribution of Medicaid recipients, by basis of eligibility and jurisdiction, in order by rank: Fiscal year 1986

Medicaid jurisdiction	Number of recipients in thousands	Percent of total	Cumulative percent of total	Basis of eligibility[1]				
				Age 65 or over	Blind	Disabled	Families with dependent children[2]	Other title XIX
				Percent distribution				
All jurisdictions	22,517.7	100.0	100.0	13.9	0.4	13.8	69.6	6.1
California	3,466.1	15.4	15.4	13.6	0.7	14.8	64.5	6.4
New York	2,322.6	10.3	25.7	15.2	0.2	13.0	65.4	6.2
Puerto Rico	1,761.8	7.8	33.5	0.0	0.1	4.3	64.2	31.4
Michigan	1,119.7	5.0	38.5	8.5	0.2	13.2	87.1	6.1
Pennsylvania	1,099.3	4.9	43.4	11.2	0.1	12.7	79.4	6.5
Ohio	1,078.9	4.8	48.2	8.8	0.2	10.4	80.6	0.0
Illinois	1,063.5	4.7	52.9	7.6	0.1	12.8	77.6	1.9
Texas	879.0	3.9	56.8	24.3	0.5	13.3	61.8	0.1
Florida	587.6	2.6	59.4	19.6	0.5	19.3	59.3	1.3
New Jersey	581.2	2.6	62.0	11.4	0.2	13.0	76.6	2.7
Massachusetts	528.9	2.3	64.3	19.6	1.4	14.5	57.5	7.0
Georgia	483.5	2.1	66.4	19.1	0.6	21.5	68.7	0.5
Louisiana	446.4	2.0	68.4	20.6	0.4	15.6	63.2	0.1
Kentucky	414.9	1.8	70.2	13.0	0.5	17.4	73.9	3.0
Wisconsin	409.4	1.8	72.0	20.8	0.3	19.1	99.5	2.5
Tennessee	394.7	1.8	73.8	18.3	0.6	21.3	57.3	2.4
North Carolina	378.2	1.7	75.5	17.8	0.4	13.5	67.0	1.2
Missouri	359.9	1.6	77.1	17.8	0.4	15.0	66.1	0.8
Washington	357.9	1.6	78.7	11.8	0.1	13.7	81.7	1.6
Minnesota	344.5	1.5	80.2	16.5	0.2	10.5	64.7	8.4
Maryland	323.4	1.4	81.6	13.2	0.1	12.0	73.4	1.3
Mississippi	318.9	1.4	83.0	19.6	0.5	19.3	57.4	3.2
Alabama	316.4	1.4	84.4	26.0	0.5	22.7	54.4	1.1
Virginia	314.2	1.4	85.8	18.3	0.4	15.7	63.1	2.5
Indiana	297.8	1.3	87.1	14.8	0.4	14.7	74.5	4.0
South Carolina	262.1	1.2	88.3	17.4	0.7	21.3	99.6	0.7
Oklahoma	242.3	1.1	89.4	22.5	0.2	11.3	64.8	1.2
Iowa	221.9	1.0	90.4	13.9	0.3	10.7	76.9	9.4
Connecticut	216.6	1.0	91.4	16.4	0.1	11.0	66.4	6.2
West Virginia	211.2	0.9	92.3	16.9	0.2	19.7	62.3	0.9

See footnotes at end of table.

Table 4.11—Continued

Number and percent distribution of Medicaid recipients, by basis of eligibility and jurisdiction, in order by rank: Fiscal year 1986

Medicaid jurisdiction	Number of recipients in thousands	Percent of total	Cumulative percent of total	Basis of eligibility[1]				
				Age 65 or over	Blind	Disabled	Families with dependent children[2]	Other title XIX
				Percent distribution				
Arkansas	203.3	0.9	93.2	25.1	0.7	21.7	46.4	6.1
Oregon	162.5	0.7	93.9	11.2	0.6	11.4	73.5	3.2
Colorado	149.0	0.7	94.6	20.3	0.1	14.0	66.8	4.6
Kansas	131.0	0.6	95.2	34.9	0.2	13.3	79.6	4.3
Maine	125.1	0.6	95.8	16.7	0.2	16.0	78.7	0.0
Nebraska	102.1	0.5	96.3	15.3	0.2	10.5	66.2	7.8
District of Columbia	98.0	0.4	96.7	9.9	0.1	15.1	71.1	3.8
Rhode Island	97.2	0.4	97.1	19.6	0.3	18.3	61.1	0.7
New Mexico	91.8	0.4	97.5	13.3	0.5	19.4	64.3	2.4
Hawaii	88.9	0.4	97.9	12.4	0.2	9.2	84.4	1.2
Utah	75.6	0.3	98.2	10.5	0.1	11.8	74.8	12.5
Montana	52.2	0.2	98.4	12.8	0.2	14.3	70.4	2.4
Vermont	50.0	0.2	98.6	14.9	0.2	14.5	68.4	2.0
Idaho	40.3	0.2	98.8	15.1	0.1	16.2	66.9	0.4
North Dakota	40.1	0.2	99.0	23.1	0.1	12.4	66.4	0.4
Delaware	39.3	0.2	99.2	13.8	0.3	13.5	74.0	4.2
South Dakota	36.7	0.2	99.4	21.7	0.4	16.5	58.2	3.2
New Hampshire	35.3	0.2	99.6	23.7	0.8	15.2	60.2	0.0
Nevada	32.5	0.1	99.7	18.8	1.3	15.8	63.6	6.2
Alaska	28.7	0.1	99.8	9.0	0.2	8.3	76.2	13.4
Wyoming	21.0	0.1	99.9	13.7	0.3	7.4	78.4	0.2
Virgin Islands	13.9	0.1	100.0	8.3	0.0	4.1	81.5	6.0

[1] The sum of percentages by basis of eligibility may exceed 100 percent because a recipient may be counted in more than one eligibility group.
[2] Includes children and adults in families with dependent children.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 4.12

Number and percent distribution of Medicaid recipients, by maintenance assistance status and basis of eligibility: Fiscal year 1986

Basis of eligibility	Number of recipients in thousands	Maintenance assistance status	
		Cash assistance	Medical assistance only
		Percent distribution	
Total	22,517.7	71.4	28.6
Age 65 or over	3,139.9	53.5	46.5
Blind	81.5	87.6	12.4
Disabled	3,099.7	77.9	22.1
Dependent children under age 21	10,030.7	81.6	18.4
Adults in families with dependent children	5,646.6	76.9	23.1
Other title XIX	1,365.9	0.0	100.0

NOTE: The sum of recipients exceeds total recipients because recipients who are eligible in more than one category are counted in each category but only once in the total.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

under 21 years of age comprised 50.4 percent of all Medicaid recipients. These individuals were proportionately high users of dental (60.5 percent) and other (57.8 percent) services. Recipients 21-64 years of age constituted 33.5 percent of all recipients and used proportionately more family planning services (67.1 percent), laboratory and radiological services (42.5 percent), and clinic services (41.1 percent). Those 65 years of age or over were especially likely to use proportionately more SNF, ICF, and home health services. Females equalled or exceeded their proportion of the recipient population in the use of almost every service.

Presented in Table 4.16 are the number of recipients and total days of care received in general hospitals, SNFs, and ICFs, along with the number of physician, rural health clinic and home health visits, and the number of drug prescriptions, by jurisdiction.

For general hospitals, total discharges are a count of hospital stays, but recipients discharged are an unduplicated count of persons. Recipient data on general hospitals reported in this table may not match data presented elsewhere because stays in general hospitals by recipients also covered by Medicare (i.e., the dually enrolled population) are excluded. In fiscal year 1986, there were 3.7 million discharges from general hospitals for this population, for a total of 29.3 million days of care.

A total of 571,135 recipients of SNF services accounted for a total of 116.0 million days of care. There were 827,755 ICF recipients who accounted for 218.0 million days of care, and 144,534 ICF/MR recipients who accounted for 48.4 million days of care.

A day of care in a general hospital, SNF, or ICF is counted only if paid for in whole or in part by Medicaid. Days of care paid entirely by sources other than Medicaid are not included. As a result, it is not possible to derive average length of stay for Medicaid patients from these data alone.

A physician visit is a consultation with a physician or person acting under a physician's supervision. When a physician's bill does not show a visit but simply a flat fee, the recipient is reported as receiving physicians' services but the number of visits is not reported. A total of 80.7 million physician visits were reported.

There was a total of 250,737 rural health clinic visits in fiscal year 1986, and 15.8 million home health visits.

The number of prescriptions includes refills but covers only drugs dispensed outside hospitals or other inpatient facilities. The number of prescriptions totaled 206.3 million in fiscal year 1986.

Other data on utilization

As noted earlier, if individuals eligible for Medicaid are also eligible for Medicare, the State can buy in for Medicare SMI coverage. The number of Medicaid eligibles enrolled as Medicare buy-ins, by jurisdiction, is shown in Table 4.17. In calendar year 1986, a total of 3.3 million Medicaid eligibles were enrolled as Medicare buy-ins.

Table 4.13

Percent of Medicaid recipients, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1986

Medicaid jurisdiction	Number of recipients in thousands	Aged			Sex		Race or ethnic origin[1]				
		Under 21 years	21-64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
					Percent						
All jurisdictions	22,517.7	50.3	33.5	16.2	36.0	64.0	54.5	29.0	2.7	3.7	10.1
Alabama	316.4	42.4	29.0	28.6	32.8	67.2	38.2	61.6	0.0	0.1	0.1
Alaska	28.7	59.5	31.9	8.6	36.4	63.6	47.9	5.8	43.1	1.2	1.9
Arkansas	203.3	38.4	30.7	30.9	34.5	65.5	55.4	44.4	0.0	0.1	0.1
California	3,466.1	49.3	33.2	17.5	37.8	62.2	50.0	17.3	0.6	6.3	25.7
Colorado	149.0	49.4	29.3	21.3	35.3	64.7	54.1	11.0	0.6	0.3	34.0
Connecticut	216.6	52.8	31.1	16.1	35.1	64.9	69.3	30.7	0.0	0.0	0.0
Delaware	39.3	54.9	31.7	13.4	33.7	66.3	39.4	55.4	0.1	0.2	4.9
District of Columbia	98.0	53.0	34.8	12.2	33.8	66.2	2.7	97.3	0.0	0.0	0.0
Florida	587.6	47.1	28.6	24.2	29.7	70.3	40.7	46.6	1.7	7.0	4.0
Georgia	483.5	47.2	30.5	22.3	32.7	67.3	36.0	63.6	0.0	0.1	0.2
Hawaii	88.9	56.0	32.8	11.2	39.9	60.1	29.3	1.1	0.0	68.3	1.3
Idaho	40.3	50.6	33.7	15.7	35.0	65.0	94.3	0.4	0.7	1.1	3.5
Illinois	1,063.5	56.1	34.1	9.8	36.4	63.6	40.9	49.1	0.1	0.9	9.0
Indiana	297.8	52.4	31.8	15.8	33.5	66.5	69.0	28.8	0.1	0.3	1.9
Iowa	221.9	52.4	33.8	13.9	37.4	62.6	90.6	6.8	0.5	1.1	1.0
Kansas	131.0	54.1	31.0	14.9	36.3	63.7	73.5	22.0	1.0	0.0	3.5
Kentucky	414.9	51.2	34.1	14.7	37.3	62.7	96.8	3.2	0.0	0.0	0.0
Louisiana	446.4	49.2	30.1	20.7	34.7	65.3	29.0	71.0	0.0	0.0	0.0
Maine	125.1	46.0	35.3	18.8	37.1	62.9	20.0	20.0	20.0	20.0	20.0
Maryland	323.4	52.4	33.3	14.3	34.2	65.8	41.0	57.4	0.2	1.1	0.4
Massachusetts	528.9	46.7	31.5	21.8	34.3	65.7	73.1	12.2	0.1	1.4	13.2
Michigan	1,119.7	60.2	31.3	8.5	38.3	61.7	61.1	35.2	0.4	0.6	2.7
Minnesota	344.5	50.2	31.3	18.5	37.8	62.2	90.4	2.9	2.5	3.5	0.6
Mississippi	318.9	48.4	27.1	24.5	34.5	65.5	22.6	76.9	0.1	0.3	0.0
Missouri	359.9	32.9	27.7	39.4	34.6	65.4	66.9	32.7	0.2	0.0	0.2

See footnotes at end of table.

Table 4.13—Continued

Percent of Medicaid recipients, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1986

Medicaid jurisdiction	Number of recipients in thousands	Aged			Sex		Race or ethnic origin[1]				
		Under 21 years	21-64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
					Percent						
Montana	52.2	49.6	35.7	14.7	37.0	63.0	83.9	0.0	14.3	0.5	1.3
Nebraska	102.1	53.5	30.8	15.6	36.5	63.5	76.0	15.6	3.8	0.9	3.7
Nevada	32.5	47.6	32.8	19.6	33.4	66.6	60.3	29.8	2.6	1.4	5.9
New Hampshire	35.3	43.8	23.6	32.6	33.3	66.7	90.6	0.5	0.0	8.2	0.7
New Jersey	581.2	55.9	30.9	13.1	34.8	65.2	36.9	41.7	0.2	0.4	20.8
New Mexico	91.8	46.8	31.5	21.7	35.4	64.6	85.0	4.6	8.9	0.0	1.6
New York	2,322.6	50.6	32.4	17.0	36.4	63.6	65.8	26.8	0.5	0.3	6.7
North Carolina	378.2	48.4	33.3	18.3	32.6	67.4	39.6	57.7	2.4	0.2	0.2
North Dakota	40.1	50.0	27.4	22.6	37.1	62.9	80.4	1.0	17.3	0.8	0.5
Ohio	1,078.9	55.5	34.3	10.1	35.6	64.4	84.0	8.1	3.5	1.8	2.6
Oklahoma	242.3	44.6	31.9	23.5	32.1	67.9	68.4	22.7	7.4	0.4	1.2
Oregon	162.5	54.6	33.4	12.0	36.0	64.0	85.3	6.9	3.6	1.7	2.4
Pennsylvania	1,099.3	57.5	31.2	11.3	37.9	62.1	61.1	32.1	0.1	1.0	5.8
Rhode Island	97.2	43.1	30.4	26.5	35.4	64.6	73.1	13.8	0.1	3.3	9.7
South Carolina	262.1	46.7	31.2	22.2	33.0	67.0	30.2	69.6	0.1	0.0	0.1
South Dakota	36.7	47.6	28.6	23.8	35.0	65.0	66.9	0.1	33.0	0.0	0.0
Tennessee	394.7	46.0	31.0	22.9	34.4	65.6	58.8	40.9	0.0	0.2	0.1
Texas	879.0	48.1	27.3	24.5	34.2	65.8	37.0	30.1	0.1	0.9	31.9
Utah	75.6	58.5	31.7	9.8	38.3	61.7	85.2	0.0	4.0	1.5	9.3
Vermont	50.0	48.8	34.5	16.7	36.8	63.2	99.1	0.3	0.2	0.4	0.0
Virginia	314.2	48.5	32.3	19.3	33.7	66.3	43.8	54.5	0.1	1.1	0.5
Washington	357.9	51.7	35.9	12.4	36.9	63.1	82.1	7.4	3.9	1.5	5.2
West Virginia	211.2	49.9	38.5	11.6	39.3	60.7	94.7	5.3	0.0	0.0	0.0
Wisconsin	409.4	46.1	35.0	18.9	38.8	61.2	82.0	9.7	3.1	2.3	2.9
Wyoming	21.0	54.6	29.4	16.0	33.1	66.9	83.8	3.0	1.5	0.2	11.5
Puerto Rico	1,761.8	45.4	51.1	3.5	37.6	62.4	20.0	20.0	20.0	20.0	20.0
Virgin Islands	13.9	57.3	34.7	8.0	39.0	61.0	20.0	20.0	20.0	20.0	20.0

[1] The race or ethnic origin of significant numbers of reicpients in some reporting States was unknown. The Bureau of Data Management and Strategy estimated the number of recipients by race or ethnic origin for these States. Data by race or ethnic origin, therefore, should be used with caution.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 4.14

Percent of Medicaid recipients, by type of service and jurisdiction: Fiscal year 1986

Medicaid jurisdiction	Number of recipients in thousands	Type of service							
		Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians'	Dental	Other practitioners'
		General hospital	Mental hospital		Mentally retarded	All other			
		Percent							
All jurisdiction	22,517.7	15.7	0.2	2.5	0.6	3.7	66.2	22.9	15.3
Alabama	316.4	18.1	0.1	1.1	0.5	5.5	79.0	11.8	11.7
Alaska	28.7	13.0	0.3	0.6	0.4	2.1	69.4	23.0	18.1
Arkansas	203.3	24.6	0.3	7.1	0.8	3.1	81.1	18.3	16.0
California	3,466.1	13.5	0.0	3.5	0.3	0.3	71.4	27.9	16.8
Colorado	149.0	8.8	0.3	9.6	0.0	0.0	71.8	15.1	7.5
Connecticut	216.6	19.0	0.6	3.3	0.7	8.9	64.9	32.7	25.7
Delaware	39.3	15.6	0.2	1.0	1.1	5.7	75.6	12.8	7.4
District of Columbia	98.0	16.9	0.6	0.4	0.6	3.0	75.8	12.0	5.7
Florida	587.6	16.5	0.0	2.0	0.6	5.8	67.3	14.5	11.3
Georgia	483.5	19.9	0.0	2.9	0.4	4.8	77.5	20.2	8.5
Hawaii	88.9	13.0	0.0	2.0	0.3	2.6	81.5	41.8	8.5
Idaho	40.3	15.3	0.0	5.4	1.3	6.6	80.5	17.0	13.2
Illinois	1,063.5	17.8	0.2	2.0	0.9	5.6	76.3	4.7	18.2
Indiana	297.8	20.4	0.2	4.2	0.8	10.4	82.3	34.8	19.1
Iowa	221.9	13.9	0.2	0.2	0.8	8.9	80.8	40.6	23.5
Kansas	131.0	12.4	0.8	0.6	1.3	10.7	82.5	22.6	11.8
Kentucky	414.9	18.1	0.2	1.3	0.3	4.0	83.4	21.1	11.2
Louisiana	446.4	19.7	0.2	0.2	1.3	6.8	69.0	13.7	3.8
Maine	125.1	16.1	0.0	0.5	0.6	7.0	79.3	22.9	20.4
Maryland	323.4	23.1	0.2	0.6	0.6	7.1	75.7	20.5	4.9
Massachusetts	528.9	21.0	0.0	3.8	0.7	4.9	67.0	30.7	20.7
Michigan	1,119.7	14.5	0.3	1.7	0.3	3.3	73.8	29.1	15.2
Minnesota	344.5	12.8	0.2	8.0	2.3	4.5	77.1	45.3	6.2
Mississippi	318.9	22.2	0.0	2.3	0.5	2.7	82.8	25.2	4.8
Missouri	359.9	19.9	0.2	0.9	0.7	7.4	63.9	28.3	15.9
Montana	52.2	20.3	0.0	0.6	0.5	9.0	78.1	24.3	24.6
Nebraska	102.1	20.0	0.2	1.5	0.9	9.0	80.2	32.0	20.3
Nevada	32.5	19.9	0.0	1.5	0.7	7.3	68.8	19.4	9.7
New Hampshire	35.3	17.1	0.5	0.2	0.8	15.7	76.8	20.5	16.7
New Jersey	581.2	14.7	0.3	0.9	0.7	5.1	74.5	31.2	20.9
New Mexico	91.8	20.0	0.0	0.3	0.7	5.0	76.3	26.2	7.4
New York	2,322.6	14.2	0.8	3.7	0.7	1.1	64.7	33.9	30.6
North Carolina	378.2	22.4	0.4	3.9	0.8	3.5	70.6	26.0	12.8
North Dakota	40.1	27.2	0.5	8.8	1.8	7.8	72.1	35.0	20.4
Ohio	1,078.9	17.5	0.1	3.9	0.8	2.5	73.6	29.3	22.3
Oklahoma	242.3	12.3	0.4	0.1	1.3	10.2	58.0	9.0	3.7
Oregon	162.5	16.0	0.3	0.6	1.1	6.5	65.3	15.4	8.8
Pennsylvania	1,099.3	16.2	0.5	1.6	0.7	5.1	56.5	28.1	11.6
Puerto Rico	1,761.8	5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Rhode Island	97.2	14.6	0.1	1.0	1.2	10.3	65.4	26.5	17.1
South Carolina	262.1	28.1	0.5	2.3	1.0	2.5	73.5	18.5	9.2
South Dakota	36.7	22.3	0.3	0.9	2.0	14.1	72.2	23.7	7.8
Tennessee	394.7	20.8	0.6	1.4	0.6	6.6	72.7	14.5	5.2
Texas	879.0	21.0	0.0	1.0	1.5	8.1	82.3	11.8	22.3
Utah	75.6	16.8	0.2	1.6	1.8	5.9	82.3	30.0	15.8
Vermont	50.0	14.1	0.1	0.9	0.5	5.9	83.4	20.9	14.7
Virgin Islands	13.9	6.3	0.0	0.0	0.0	0.0	0.6	15.7	0.0
Virginia	314.2	19.4	0.4	0.7	1.0	5.9	80.4	15.7	7.3
Wasington	357.9	13.2	0.2	6.2	0.8	0.4	81.7	21.1	20.6
West Virginia	211.2	16.2	0.0	1.5	0.1	2.3	76.1	23.5	15.8
Wisconsin	409.4	12.5	0.3	8.7	0.6	5.4	54.9	33.5	14.8
Wyoming	21.0	17.2	0.1	1.8	0.0	8.7	71.3	29.2	11.8

See footnotes at end of table.

Table 4.14—Continued

Percent of Medicaid recipients, by type of service and jurisdiction: Fiscal year 1986

Medicaid jurisdiction	Number of recipients in thousands	Type of service						
		Outpatient hospital	Clinic	Laboratory and radiological	Home health	Prescribed drugs	Family planning	Other[1]
		Percent						
All jurisdictions	22,517.7	47.6	9.0	31.6	2.6	65.3	7.7	24.7
Alabama	316.4	32.3	2.9	38.4	2.9	73.1	7.8	25.4
Alaska	28.7	61.8	22.1	1.4	0.2	0.0	4.4	23.8
Arkansas	203.3	34.8	4.7	29.2	6.0	82.8	4.9	22.6
California	3,466.1	39.4	8.9	48.4	0.5	67.6	6.4	28.9
Colorado	149.0	42.5	7.9	13.6	1.5	66.3	8.7	43.0
Connecticut	216.6	53.8	16.1	16.8	3.2	70.9	9.1	25.4
Delaware	39.3	50.9	4.7	9.8	2.4	72.7	12.9	8.5
District of Columbia	98.0	53.4	8.4	22.5	3.2	65.1	7.2	27.6
Florida	587.6	31.9	3.1	37.9	5.9	74.6	4.5	34.3
Georgia	483.5	47.4	4.2	8.5	2.3	78.7	8.4	30.0
Hawaii	88.9	29.2	6.0	32.9	0.5	75.0	6.6	10.5
Idaho	40.3	40.5	6.4	50.8	2.3	64.9	7.2	21.3
Illinois	1,063.5	40.9	11.2	42.1	2.0	76.6	10.5	24.3
Indiana	297.8	51.7	21.4	8.8	0.9	79.8	5.0	31.2
Iowa	221.9	41.4	3.0	11.3	2.2	75.4	10.8	18.6
Kansas	131.0	29.7	9.7	18.4	1.8	64.3	5.7	21.8
Kentucky	414.9	43.4	11.6	7.8	3.6	71.5	8.8	10.6
Louisiana	446.4	48.1	3.8	73.6	1.2	75.7	9.5	32.6
Maine	125.1	58.8	5.6	5.2	3.9	73.3	8.9	20.8
Maryland	323.4	46.4	9.3	22.7	2.0	72.0	11.5	30.0
Massachusetts	528.9	53.3	15.9	13.3	4.6	70.1	7.7	40.4
Michigan	1,119.7	38.9	2.2	20.7	1.0	65.6	11.5	26.9
Minnesota	344.5	41.3	1.1	8.1	14.3	69.5	8.5	38.8
Mississippi	318.9	40.2	0.0	13.3	1.3	78.9	10.4	29.6
Missouri	359.9	44.8	35.3	18.5	1.6	73.6	10.1	12.7
Montana	52.2	38.6	4.8	12.0	1.2	67.5	9.0	40.1
Nebraska	102.1	36.9	1.9	32.1	1.5	72.9	6.7	26.4
Nevada	32.5	39.6	2.8	21.0	2.4	63.4	7.0	51.8
New Hampshire	35.3	44.6	10.7	12.0	4.9	74.6	4.7	33.0
New Jersey	581.2	43.9	10.1	33.7	1.5	80.9	8.5	18.4
New Mexico	91.8	45.0	9.0	12.3	1.4	72.5	8.5	32.3
New York	2,322.6	48.4	15.4	40.2	8.8	69.1	9.3	21.9
North Carolina	378.2	42.8	9.2	49.6	2.5	69.5	9.0	23.7
North Dakota	40.1	27.4	4.5	16.2	3.8	62.7	6.7	30.8
Ohio	1,078.9	55.1	11.0	48.9	0.7	71.6	10.1	25.9
Oklahoma	242.3	8.2	1.2	1.8	0.1	47.2	1.7	16.7
Oregon	162.5	40.2	6.2	46.6	2.8	66.2	7.7	47.2
Pennsylvania	1,099.3	50.4	13.7	29.1	1.0	67.8	8.8	28.6
Puerto Rico	1,761.8	100.0	0.0	13.2	0.0	0.0	0.0	0.0
Rhode Island	97.2	45.1	0.0	0.0	2.7	74.6	5.8	31.2
South Carolina	262.1	41.3	3.4	7.2	2.4	70.4	8.7	26.7
South Dakota	36.7	39.4	7.6	38.1	3.6	59.7	5.0	21.8
Tennessee	394.7	44.3	15.4	44.6	2.1	73.0	6.0	23.5
Texas	879.0	36.8	0.0	51.1	4.3	78.1	7.1	22.3
Utah	75.6	36.8	1.8	7.7	0.8	67.7	1.1	10.2
Vermont	50.0	42.0	9.1	5.7	4.7	74.3	9.7	18.6
Virgin Islands	13.9	85.3	0.0	33.4	0.0	59.5	4.8	11.8
Virginia	314.2	52.1	12.3	0.3	1.9	73.5	11.1	26.2
Washington	357.9	41.0	6.7	44.7	1.3	70.9	13.3	38.2
West Virginia	211.2	33.1	5.5	15.4	0.5	67.6	5.4	36.1
Wisconsin	409.4	41.3	35.9	41.5	2.4	67.4	8.8	37.0
Wyoming	21.0	39.9	0.0	16.7	0.8	0.0	3.9	7.5

[1] Includes early and periodic screening, diagnosis, and treatment services; rural health care; and other services.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 4.15

Percent distribution of Medicaid recipients, by age, sex, race or ethnic origin, and type of service: Fiscal year 1986

Type of service	Number of recipients in thousands	Age				Sex		Race or ethnic origin[1]				
		Under 6 years	6-20 years	21-64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
		Percent of recipients										
All services	22,518	21.5	28.9	33.5	16.1	36.0	64.0	54.5	29.0	2.7	3.7	10.1
Inpatient hospital	3,597	18.1	17.4	39.6	24.9	29.3	70.7	58.8	29.3	1.7	2.0	8.2
Skilled nursing facility	571	0.9	1.0	18.1	80.1	28.4	71.6	89.2	8.3	0.3	0.8	1.5
Intermediate care facility[2]	973	0.4	2.7	21.7	75.2	31.4	68.6	87.2	10.6	0.5	0.8	1.5
Physicians'	14,897	22.6	27.3	32.7	17.4	34.8	65.2	58.6	28.8	1.0	2.4	9.2
Dental	5,162	15.2	45.3	32.0	7.6	36.9	63.1	59.9	26.5	1.2	2.7	9.8
Other practioners'	3,451	6.8	30.6	39.2	23.4	30.3	69.7	64.7	24.8	1.0	1.7	7.8
Outpatient hospital	10,711	22.1	27.2	39.9	10.9	35.4	64.6	50.9	29.6	4.3	4.6	10.6
Clinic	2,033	21.2	28.0	41.1	9.7	36.1	63.9	56.0	32.1	1.2	2.1	8.6
Laboratory and radiological	7,122	16.4	26.2	42.5	14.9	30.1	69.9	55.6	30.4	0.9	2.3	10.7
Home health	593	10.4	6.6	33.8	49.2	28.0	72.0	67.7	25.5	0.8	2.3	3.8
Prescribed drugs	14,704	21.1	25.2	34.6	19.1	35.1	64.9	58.4	29.3	0.9	2.3	9.0
Family planning	1,733	0.0	32.9	67.1	0.0	1.8	98.2	57.1	37.8	0.9	1.3	8.2
Other	5,570	32.3	25.5	22.0	20.2	38.9	61.1	56.0	32.2	1.2	2.0	8.6

[1] The race or ethnic origin of significant numbers of recipients in some reporting States are unknown. The Bureau of Data Management and Strategy estimated recipients and payments by race or ethnic origin for these States. Data by race or ethnic origin, therefore, should be used with caution.

[2] Figures include intermediate care facilities (ICFs) for the mentally retarded and all other ICFs. Recipients within the category of 21-64 years reflect mainly use of ICFs for the mentally retarded. Recipients within the age category of 65 years or over reflect mainly use of all other ICFs.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 4.16

Selected measures of use of services by Medicaid recipients, by jurisdiction: Fiscal year 1986

Medicaid jurisdiction	General hospital[1]			SNF[2]		ICF[3]		ICF/MR[4]		Physician visits[5]	Rural health visits	Home health visits	Number of drug prescriptions
	Discharges	Recipients discharged	Days of care	Recipients	Days of care	Recipients	Days of care	Recipients	Days of care				
All jurisdictions	3,669,579	2,537,164	29,336,097	571,135	116,043,944	827,755	217,972,168	144,534	48,418,296	80,748,147	250,737	15,807,172	206,322,288
Alabama	48,187	37,254	195,845	3,594	404,314	17,398	4,730,401	1,431	487,103	658,438	3,835	184,188	3,537,798
Alaska	2,708	1,944	60,178	414	52,591	318	77,234	42	566	82,182	1,269	810	0
Arkansas	35,406	26,839	201,521	14,472	3,611,900	6,351	1,604,675	1,527	737.482	1,147,250	0	158,618	1,648,727
California	429,740	326,820	2,648,440	119,820	23,760,020	9,600	1,064,220	9,960	3,001,100	9,315,940	0	132,480	24,878,760
Colorado	13,267	10,276	84,072	14,261	3,856,182	0	0	0	0	1,288,960	6,090	147,249	1,426,323
Connecticut	72,782	37,687	334,920	7,099	683,812	19,378	5,278,735	1,507	439,929	453,619	0	1,222,325	2,565,658
Delaware	6,353	5,054	29,792	377	47,021	2,224	502,549	438	150,062	212,669	0	0	302,328
District of Columbia	21,813	13,382	171,246	358	44,927	2,944	781,751	595	193,457	888,353	0	678,096	773,715
Florida	92,387	70,789	613,380	11,584	1,481,772	33,903	8,279,696	3,439	1,142,218	1,299,334	22,323	64,688	7,447,022
Georgia	91,136	63,435	530,317	13,957	2,846,477	23,246	6,597,249	1,762	725,490	1,108,164	9,056	523,135	6,436,664
Hawaii	14,138	10,600	71,981	1,798	240,424	2,291	562,944	240	56,528	398,683	0	1,847	837,775
Idaho	6,594	4,622	31,059	2,186	304,072	2,678	745,135	512	194,725	123,661	1,609	11,353	213,013
Illinois	229,066	160,338	1,428,230	21,377	3,743,186	59,720	15,293,396	9,768	2,770,650	4,609,227	0	334,070	12,652,734
Indiana	73,992	46,731	397,573	12,366	3,065,634	31,070	9,884,308	2,241	685,037	1,244,252	0	0	4,039,039
Iowa	33,044	24,485	163,586	474	38,593	19,800	5,568,408	1,858	628,677	857,549	3,399	3,177	2,297,548
Kansas	28,111	15,361	161,187	738	94,056	14,053	4,444,825	1,737	825,239	342,819	0	16,433	1,349,059
Kentucky	84,001	56,798	394,036	5,471	703,789	16,583	4,269,724	1,266	430,518	2,566,235	18,400	633,856	3,678,658
Louisiana	74,785	57,654	384,534	961	134,227	30,547	8,244,939	5,791	1,944,985	1,328,832	0	111,346	5,763,125
Maine	29,440	21,950	120,121	645	65,613	8,734	2,414,048	714	246,642	471,978	25,364	93,641	1,264,387
Maryland	67,894	49,176	354,821	2,005	203,514	23,046	5,022,904	1,810	613,327	1,109,343	3,027	71,209	2,729,777
Massachusetts	137,870	59,132	2,203,948	20,345	4,606,166	25,922	7,115,971	3,501	1,105,126	339,773	0	1,067,027	5,132,831
Michigan	181,095	138,830	1,054,244	19,072	2,786,124	37,074	9,036,221	3,639	1,230,843	9,234,601	0	156,415	9,807,882
Minnesota	70,300	50,689	405,895	27,487	3,030,321	15,427	6,940,026	8,035	4,300,857	1,866,590	0	127,890	3,807,849
Mississippi	68,046	39,766	188,439	7,301	1,768,999	8,467	2,264,948	1,606	546,095	788,116	8,505	47,354	2,985,704
Missouri	66,558	47,028	398,179	3,315	231,671	26,557	7,015,794	2,623	458,647	3,037,034	0	59,695	3,797,350
Montana	11,636	8,348	57,036	319	32,993	4,687	1,262,283	265	91,434	165,184	0	10,963	509,079
Nebraska	21,097	15,504	100,877	1,567	304,107	9,160	2,526,724	896	306,736	561,408	0	366,619	1,259,465
Nevada	6,339	3,949	34,000	489	42,996	2,371	561,384	218	67,862	135,943	187	6,148	244,628
New Hampshire	6,428	4,046	34,914	59	7,075	5,565	1,613,592	300	95,225	99,494	3	6,567	476,638
New Jersey	103,177	64,821	773,423	5,196	717,269	29,352	7,778,670	4,031	1,359,137	2,166,955	0	627,025	6,598,239
New Mexico	19,489	13,666	82,251	280	24,158	4,590	1,107,123	643	214,768	299,193	7,740	43,335	912,484
New York	446,108	278,260	9,828,602	86,524	23,128,460	24,957	6,899,311	16,672	5,671,116	10,230,128	0	5,496,703	29,240,882
North Carolina	71,383	51,357	442,206	14,563	2,648,483	13,081	3,397,170	3,160	1,037,174	952,919	39,479	365,128	3,666,889
North Dakota	14,765	7,982	56,634	3,54n	702,921	3,119	690,405	719	198,243	109,240	0	323,279	488,853
Ohio	201,982	153,425	1,094,096	41,859	10,685,372	27,357	7,534,744	8,123	2,113,415	1,908,324	30,675	13,070	11,076,851

See footnotes at end of table.

Table 4.16—Continued

Selected measures of use of services by Medicaid recipients, by jurisdiction: Fiscal year 1986

Medicaid jurisdiction	General hospital[1]			SNF[2]		ICF[3]		ICF/MR[4]		Physician visits[5]	Rural health visits	Home health visits	Number of drug prescriptions
	Discharges	Recipients discharged	Days of care	Recipients	Days of care	Recipients	Days of care	Recipients	Days of care				
Oklahoma	40,403	29,837	314,711	155	31,789	24,771	5,800,479	3,178	817,447	891,942	0	974	782,688
Oregon	43,770	25,909	190,801	1,032	94,487	10,618	2,701,855	1,727	589,103	373,773	1,133	65,380	1,581,200
Pennsylvania	167,893	128,960	846,248	17,587	2,235,354	55,989	13,641,056	7,943	2,769,116	3,308,643	38,801	219,413	10,495,973
Puerto Rico	0	0	0	0	0	0	0	0	0	0	0	0	0
Rhode Island	26,018	14,207	411,398	979	89,979	10,011	2,395,654	1,157	402,667	283,108	2,847	23,987	1,027,754
South Carolina	70,000	40,213	253,105	6,130	1,333,826	6,600	1,895,382	2,611	877,106	977,032	1,382	95,616	1,996,969
South Dakota	8,376	5,642	78,885	325	53,203	5,183	1,420,947	743	245,685	109,219	7,204	227,251	327,719
Tennessee	75,804	56,158	315,582	5,560	606,304	25,940	6,858,689	2,545	857,663	1,888,958	0	172,567	4,915,047
Texas	161,915	126,598	751,708	8,367	1,082,549	70,824	18,611,649	13,402	4,504,116	5,125,502	0	33,029	7,315,825
Utah	15,827	10,814	106,076	1,245	53,412	4,491	1,166,321	1,330	453,441	572,898	1,941	19,582	744,697
Vermont	9,880	6,446	54,682	426	14,616	2,953	758,478	248	97,003	430,641	10,168	183,148	533,317
Virgin Islands	973	846	5,996	0	0	0	0	0	0	576	0	0	34,972
Virginia	57,404	43,010	301,154	2,095	247,919	18,650	4,978,298	3,262	1,012,998	1,104,275	0	106,240	4,035,556
Washington	59,071	36,164	277,513	22,196	5,541,294	1,273	291,353	2,769	929,477	1,446,393	3,129	142,904	2,972,499
West Virginia	344	326	4,656	3,164	790,831	4,780	1,193,039	254	68,101	1,226,820	2,166	0	1,347,179
Wisconsin	50,784	34,036	291,999	35,633	7,769,142	22,279	5,147,461	2,296	723,960	1,605,977	1,005	1,411,342	4,363,159
Wyoming	—	—	—	368	—	1,823	—	0	—	—	—	—	—

[1] Values reported for general hospital refer only to the nondually enrolled population (i.e., Medicaid recipients who were not also enrolled in Medicare). Recipient counts for this service type reported in other tables are not restricted in this way.
[2] Skilled nursing facility.
[3] Intermediate care facility, other than for the mentally retarded.
[4] Intermediate care facility for the mentally retarded.
[5] Claims for physician visits for the dually enrolled are included only if a physician visit procedure appeared on the claim.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 4.17

Medicaid eligibles enrolled as Medicare buy-ins, and persons served, by jurisdiction: Calendar year 1986

Medicaid jurisdiction	Number of State buy-ins enrolled in thousands	Number of persons with reimbursed services[1] in thousands	Medicaid jurisdiction	Number of State buy-ins enrolled in thousands	Number of persons with reimbursed services[1] in thousands
All jurisdictions	3,321.0	2,720.4	Montana	9.6	7.9
Alabama	112.0	89.9	Nebraska	8.2	6.4
Alaska[2]	3.5	2.3	Nevada	6.5	5.9
Arizona	20.5	15.0	New Hampshire	3.7	3.2
Arkansas	71.4	58.3	New Jersey	89.9	76.1
California	643.2	544.5	New Mexico	20.5	16.1
Colorado	38.7	31.7	New York	224.6	177.3
Connecticut	16.0	13.6	North Carolina	77.6	68.7
Delaware	4.4	3.5	North Dakota	4.0	3.5
District of Columbia	14.2	11.9	Ohio	104.1	93.4
Florida	160.4	128.8	Oklahoma	45.7	35.4
Georgia	132.5	110.4	Oregon	25.7	22.6
Guam	0.7	0.5	Pennsylvania	100.5	76.3
Hawaii	10.9	9.6	Puerto Rico[2]	0.0	1.4
Idaho	8.0	6.8	Rhode Island	11.0	8.6
Illinois	51.8	44.3	South Carolina	73.0	53.5
Indiana	55.4	48.7	South Dakota	6.0	4.6
Iowa	38.6	30.9	Tennessee	89.3	67.7
Kansas	26.7	22.8	Texas	251.5	206.5
Kentucky	66.4	48.5	Utah	9.0	7.8
Louisiana[2]	0.7	6.1	Vermont	6.6	5.3
Maine	16.9	13.5	Virgin Islands	0.7	0.2
Maryland	50.3	42.8	Virginia	72.6	62.3
Massachusetts	84.0	68.8	Washington	52.8	44.5
Michigan	76.7	63.8	West Virginia	24.6	18.0
Minnesota	18.8	15.6	Wisconsin	52.0	40.7
Mississippi	94.5	75.3	Wyoming[2]	0.0	0.2
Missouri	51.0	42.3			

[1] Based on supplementary medical insurance bills (physicians', outpatient, home health, and other suppliers of services) paid January 1984-March, 1986. Recipient counts correspond to the State of residence at the time the bill was processed, which need not be the State which bought in for that person.

[2] No buy-in agreement; therefore, the number of State buy-ins enrolled at any time is zero. However, recipient counts are attributed to the person's State of residence at the time the bill was processed.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Entitlement Requirements.

Medicaid payments

Information on Medicaid payments by eligibility and demographic group, service category, and for selected other characteristics is presented in this section. Except where noted, payment data represent Federal and State shares of payments for medical assistance. Administrative and training costs are not included.

Payments by eligibility category and demographic group

The amount and percent of Medicaid payments by eligibility category and jurisdiction in rank order for fiscal year 1986 are shown in Table 4.18. Federal and State payments for services to Medicaid recipients totaled $41.0 billion in fiscal year 1986. The aged accounted for the largest share of these payments (36.8 percent) although this group represented only 13.9 percent (Table 4.11) of all Medicaid recipients. The blind and disabled also accounted for a disproportionate share of total vendor payments (36.4 percent of all payments as opposed to 14.2 percent of recipients). In contrast, recipients in families with dependent children accounted for only 24.4 percent of total Medicaid payments but 69.6 percent of all recipients (Table 4.11).

New York and California combined accounted for 30.7 percent of all Medicaid payments; the top six States accounted for 49 percent of the total. These six States (New York, California, Ohio, Pennsylvania, Mighigan, and Illinois) also accounted for 45.1 percent of all recipients (Table 4.11).

The amount and percent distribution of Medicaid payments by maintenance assistance status and basis of eligibility are presented in Table 4.19. Cash assistance recipients accounted for 51.3 percent of total vendor payments; medical assistance only recipients accounted for 48.7 percent. Except for the category of age 65 or over, cash assistance recipients accounted for the larger share of Medicaid payments in each eligibility group (other title XIX recipients could only be in the medical assistance only group).

Medicaid jurisdictions are ranked in Table 4.20 by number of recipients and amount of payments (shown in Tables 4.11 and 4.18, respectively). The two rankings are closely related. The most notable exception is Puerto Rico which ranks third in terms of recipients but 39th in terms of payments. This inconsistency reflects the congressionally mandated limit on Medicaid expenditures in the territories (see Medicaid financing section).

The percent distribution of Medicaid payments by age, sex, race or ethnic group, and jurisdiction are shown in Table 4.21. Though results vary considerably by jurisdiction, several patterns are apparent. Individuals under 21 years of age represented a smaller

Table 4.18

Amount and percent distribution of Medicaid payments, by basis of eligibility and jurisdiction, in order by rank: Fiscal year 1986

Medicaid jurisdiction	Payments in millions	Percent of total	Cumulative percent of total	Basis of eligibility				
				Age 65 or over	Blind	Disabled	Families with dependent children[1]	Other title XIX
			Percent distribution					
All jurisdictions	$41,027.3	100.0	100.0	36.8	0.7	35.7	24.4	2.4
New York	8,223.3	20.0	20.0	48.6	0.8	32.3	16.6	1.6
California	4,405.2	10.7	30.7	23.7	1.0	38.7	31.8	4.9
Ohio	2,049.5	5.0	35.7	29.2	0.3	32.6	37.9	0.0
Pennsylvania	1,992.8	4.9	40.6	36.6	0.2	32.8	28.3	2.0
Michigan	1,767.8	4.3	44.9	22.8	0.4	35.5	37.4	3.9
Illinois	1,675.0	4.1	49.0	21.5	0.3	45.7	31.1	1.4
Massachusetts	1,664.8	4.1	53.1	41.3	2.2	36.7	16.7	3.0
Texas	1,628.4	4.0	57.1	40.3	0.7	36.0	22.9	0.0
New Jersey	1,281.4	3.1	60.2	36.5	0.3	33.9	25.3	4.0
Minnesota	1,044.4	2.5	62.7	43.2	0.5	38.3	14.7	3.3
Florida	1,003.3	2.4	65.1	43.5	0.6	38.5	16.7	0.8
Wisconsin	919.7	2.2	67.3	42.9	0.6	38.0	17.6	0.9
Indiana	828.4	2.0	69.3	36.2	0.5	38.0	23.4	1.9
Georgia	818.1	2.0	71.3	31.5	0.9	40.7	26.8	0.2
Louisiana	779.6	1.9	73.2	35.1	0.7	39.1	25.1	0.0
North Carolina	750.8	1.8	75.0	35.7	0.7	35.1	24.6	3.7
Tennessee	714.4	1.7	76.7	31.7	0.7	36.8	27.0	3.8
Maryland	680.0	1.7	78.4	36.4	0.1	32.2	30.4	0.8
Connecticut	675.3	1.6	80.0	49.3	0.2	28.6	16.8	5.1
Washington	625.4	1.5	81.5	32.7	0.2	37.2	28.9	1.0
Virginia	594.6	1.4	82.9	42.2	0.5	36.6	19.3	1.5
Missouri	555.8	1.4	84.3	45.1	0.6	31.5	22.4	0.3
Kentucky	536.6	1.3	85.6	28.7	0.7	38.6	28.8	3.2
Arkansas	433.9	1.1	86.7	32.9	0.8	43.2	16.1	6.9
Oklahoma	422.3	1.0	87.7	38.4	0.2	31.9	27.7	1.9
Alabama	409.6	1.0	88.7	39.0	0.6	39.5	20.5	0.4
South Carolina	393.8	1.0	89.7	30.6	0.8	42.6	25.6	0.4
Iowa	374.4	0.9	90.6	30.3	0.4	35.2	28.5	5.6
Mississippi	316.6	0.8	91.4	39.8	0.8	33.7	24.5	1.2
Colorado	300.2	0.7	92.1	37.7	0.8	40.9	16.6	3.9
Maine	282.8	0.7	92.8	42.7	0.2	33.5	23.7	0.0
Rhode Island	262.7	0.6	93.4	45.7	0.5	41.4	12.3	0.2
Oregon	260.4	0.6	94.0	32.3	2.6	36.2	27.4	1.5
Kansas	238.5	0.6	94.6	40.4	0.2	31.7	21.2	6.4
District of Columbia	201.3	0.5	95.1	40.7	0.1	40.9	16.6	1.7
West Virginia	200.8	0.5	95.6	39.0	0.3	27.4	32.7	0.6
Nebraska	187.5	0.5	96.1	39.3	0.4	30.9	23.7	5.7
New Mexico	164.8	0.4	96.5	26.9	1.3	40.4	29.1	2.3
Puerto Rico	155.9	0.4	96.9	0.0	0.1	4.7	56.7	38.4
Utah	140.3	0.3	97.2	24.1	0.2	39.3	27.4	9.0
Hawaii	136.7	0.3	97.5	42.6	0.4	23.6	32.9	0.4
New Hampshire	133.1	0.3	97.8	54.3	2.1	33.3	10.3	0.0
North Dakota	121.7	0.3	98.1	47.5	0.1	32.1	18.7	1.6
Montana	112.0	0.3	98.4	37.4	0.3	36.4	24.8	1.1
South Dakota	102.9	0.3	98.7	42.7	0.4	40.8	15.0	1.1
Vermont	94.6	0.2	98.9	37.6	0.2	39.5	21.6	1.1
Idaho	85.5	0.2	99.1	37.2	0.1	41.5	20.4	0.9
Alaska	85.1	0.2	99.3	27.0	0.5	34.3	25.5	12.8
Nevada	79.2	0.2	99.5	32.7	2.0	40.9	21.8	2.6
Delaware	79.1	0.2	99.7	41.2	0.5	33.8	23.6	0.9
Wyoming	32.8	0.1	100.0	49.5	0.3	15.0	35.1	0.1
Virgin Islands	4.1	0.0	100.0	12.1	0.0	10.2	73.3	4.3

[1] Includes children and adults in families with dependent children.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 4.19

Amount and percent distribution of Medicaid payments, by maintenance assistance status and basis of eligibility: Fiscal year 1986

Basis of eligibility	Total payments in millions	Maintenance assistance status	
		Cash assistance	Medical assistance only
		Percent distribution	
Total	$41,027.3	51.3	48.7
Age 65 or over	15,099.8	25.1	74.9
Blind	277.5	67.8	32.2
Disabled	14,646.8	60.8	39.2
Dependent children under age 21	5,135.8	81.4	18.6
Adults in families with dependent children	4,876.8	81.6	18.4
Other title XIX	990.7	0.0	100.0

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

proportion of Medicaid payments (Table 4.21) than of Medicaid recipients (Table 4.13) (19.6 percent versus 50.3 percent); individuals 65 years of age or over accounted for a larger proportion of payments than of recipients (39.3 percent of all Medicaid payments but only 16.2 percent of recipients). Females accounted for roughly comparable proportions of payments and recipients (65.5 percent and 64.0 percent, respectively). White persons accounted for 72.2 percent of Medicaid payments but 54.5 percent of recipients; black persons accounted for 21.0 percent of all payments and 29.0 percent of recipients; and other racial or ethnic categories accounted for 6.8 percent and 16.5 percent of payments and recipients, respectively. These differences in part reflect the fact that white persons represented a high proportion of the recipients of long-term-care services (Table 4.15). Note again, however, that the race or ethnic origin of significant portions of payments and recipients are reported as "unknown" by the States, and counts are estimated by HCFA's Bureau of Data Management and Strategy. Therefore, breakdowns by race or ethnic origin should be interpreted with caution.

Payments by type of service

The percent distribution of Medicaid payments for various medical services by jurisdiction is shown in Table 4.22. By far, the largest part of Medicaid payments went for long-term-care services. Together, SNF, ICF, and ICF/MR services accounted for 42.7 percent of all Medicaid payments. Individually, 13.8 percent of all Medicaid payments (Table 4.22) were accounted for by the 2.5 percent of Medicaid recipients (Table 4.14) using SNF services, 16.5 percent of payments were accounted for by the 3.7 percent of recipients using ICF services, and 12.4 percent of all payments were accounted by the 0.6 percent of recipients who use ICF/MR services. Inpatient general hospital services accounted for another 25.3 percent of Medicaid payments. Overall, long-term care and inpatient hospital services accounted for more than two-thirds of all Medicaid payments. Physicians' services

Table 4.20

Medicaid jurisdictions ranked by number of recipients and payments for recipients: Fiscal year 1986

Medicaid jurisdiction	Number of recipients	Amount of payments
	Rank order	
California	1	2
New York	2	1
Puerto Rico	3	39
Michigan	4	5
Pennsylvania	5	4
Ohio	6	3
Illinois	7	6
Texas	8	8
Florida	9	11
New Jersey	10	9
Massachusetts	11	7
Georgia	12	14
Louisiana	13	15
Kentucky	14	23
Wisconsin	15	12
Tennessee	16	17
North Carolina	17	16
Missouri	18	22
Washington	19	20
Minnesota	20	10
Maryland	21	18
Mississippi	22	29
Alabama	23	26
Virginia	24	21
Indiana	25	13
South Carolina	26	27
Oklahoma	27	25
Iowa	28	28
Connecticut	29	19
West Virginia	30	36
Arkansas	31	24
Oregon	32	33
Colorado	33	30
Kansas	34	34
Maine	35	31
Nebraska	36	37
District of Columbia	37	35
Rhode Island	38	32
New Mexico	39	38
Hawaii	40	41
Utah	41	40
Montana	42	44
Vermont	43	46
Idaho	44	47
North Dakota	45	43
Delaware	46	50
South Dakota	47	45
New Hampshire	48	42
Nevada	49	49
Alaska	50	48
Wyoming	51	51
Virgin Islands	52	52

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

accounted for 6.2 percent of all payments, and prescription drugs accounted for 6.6 percent.

The percent distribution of Medicaid payments by type of medical service and age, sex, and race or ethnic origin are shown in Table 4.23. Within service category, the percent distribution of Medicaid payments (Table 4.23) generally more closely parallels the percent distribution of Medicaid recipients (Table 4.15) than was the case for all services noted above. Differences in payments between demographic groups noted previously thus partially reflect different patterns of utilization by these groups.

Table 4.21

Average Medicaid payment per recipient, by jurisdiction, and percent distribution of payments, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1986

Medicaid jurisdiction	Total payments in millions	Payment per recipient	Age			Sex		Race or ethnic origin[1]				
			Under 21 years	21-64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
						Percent						
All jurisdiction	$41,027.3	$1,822	19.6	41.1	39.3	34.5	65.5	72.2	21.0	0.9	1.4	4.5
Alabama	409.6	1,295	16.2	39.7	44.2	30.1	69.9	58.5	41.4	0.0	0.0	0.0
Alaska	85.1	2,965	29.8	44.2	25.9	38.1	61.9	54.6	5.1	37.8	1.4	1.1
Arkansas	433.9	2,134	25.4	37.0	37.6	38.4	61.6	70.6	29.2	0.0	0.1	0.0
California	4,405.2	1,271	23.9	48.5	27.6	36.9	63.1	64.9	15.5	0.3	3.0	16.2
Colorado	300.2	2,014	15.5	32.0	52.5	29.9	70.1	75.5	6.3	0.4	0.3	17.5
Connecticut	675.3	3,117	15.7	36.0	48.3	33.7	66.3	85.9	14.1	0.0	0.0	0.0
Delaware	79.1	2,014	18.1	40.6	41.3	32.3	67.7	59.2	38.0	0.1	0.1	2.5
District of Columbia	201.3	2,053	13.2	42.7	44.1	37.6	62.4	13.5	86.5	0.0	0.0	0.0
Florida	1,003.3	1,707	14.5	31.5	54.0	31.3	68.9	64.3	25.8	0.7	7.6	1.7
Georgia	818.1	1,692	20.5	42.2	37.3	29.9	70.1	54.1	45.7	0.0	0.0	0.1
Hawaii	136.7	1,537	19.1	38.3	42.6	35.9	64.1	26.2	0.7	0.0	72.0	1.2
Idaho	85.5	2,121	20.6	41.3	38.1	35.8	64.2	96.2	0.5	0.4	1.3	1.6
Illinois	1,675.0	1,575	22.2	49.5	28.2	36.1	63.9	58.1	36.2	0.1	0.6	5.0
Indiana	828.4	2,782	17.7	41.4	40.9	31.9	68.1	81.1	17.7	0.0	0.2	1.0
Iowa	374.4	1,687	23.9	45.0	31.2	36.3	63.7	78.4	16.1	1.9	1.5	2.2
Kansas	238.5	1,820	23.9	38.4	37.7	36.7	63.3	86.9	11.0	0.5	0.0	1.6
Kentucky	536.6	1,293	25.3	44.6	30.1	33.9	66.1	93.1	6.9	0.0	0.0	0.0
Louisiana	779.6	1,746	23.0	41.6	35.4	35.0	65.0	51.5	48.5	0.0	0.0	0.0
Maine	282.8	2,261	13.7	40.1	46.2	33.5	66.5	20.0	20.0	20.0	20.0	20.0
Maryland	680.0	2,103	20.9	40.8	38.3	34.2	65.8	56.3	42.6	0.1	0.6	0.4
Massachusetts	1,664.8	3,148	14.9	40.3	44.8	34.9	65.1	87.4	8.2	0.1	0.4	3.8
Michigan	1,767.8	1,579	26.9	48.1	25.1	34.3	65.7	67.1	31.0	0.2	0.4	1.2
Minnesota	1,044.4	3,032	13.8	37.5	48.7	37.0	63.0	96.4	1.4	1.2	0.8	0.2
Mississippi	316.6	993	18.3	35.5	46.3	30.0	70.0	44.0	55.7	0.1	0.1	0.0
Missouri	555.8	1,544	13.7	33.6	52.7	30.6	69.4	78.8	20.9	0.1	0.0	0.1

See footnotes at end of table

Table 4.21—Continued

Average Medicaid payment per recipient, by jurisdiction, and percent distribution of payments, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1986

Medicaid jurisdiction	Total payments in millions	Payment per recipient	Age			Sex		Race or ethnic origin[1]				
			Under 21 years	21-64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
						Percent						
Montana	$112.0	$2,145	16.8	41.5	41.7	35.4	64.6	89.9	0.0	9.2	0.2	0.7
Nebraska	187.5	1,838	21.7	38.3	40.0	34.5	65.5	85.9	9.9	2.2	0.4	1.5
Nevada	79.2	2,435	21.4	44.2	34.4	35.9	64.1	61.3	28.1	3.8	1.6	5.1
New Hampshire	133.1	3,765	17.9	28.8	53.4	22.0	78.0	83.6	0.2	0.0	16.0	0.1
New Jersey	128.4	2,205	19.2	41.3	39.5	32.7	67.3	65.2	27.1	0.1	0.1	7.5
New Mexico	164.8	1,794	24.0	44.7	31.3	35.6	64.4	82.5	8.1	7.0	0.0	2.4
New York	8,223.3	3,541	14.2	34.7	51.1	34.6	65.4	76.6	20.4	0.2	0.1	2.7
North Carolina	750.8	1,985	20.0	43.4	36.6	34.8	65.2	58.9	39.5	1.5	0.1	0.1
North Dakota	121.7	3,030	16.5	36.7	46.8	37.0	63.0	90.4	35.5	33.6	66.4	51.8
Ohio	2,049.5	1,900	28.4	53.5	18.2	34.1	65.9	89.6	5.3	1.9	1.5	1.7
Oklahoma	422.3	1,743	24.0	36.9	39.1	35.7	64.3	80.0	13.6	5.3	0.2	0.8
Oregon	260.4	1,602	21.5	45.2	33.3	35.2	64.8	92.0	4.0	1.5	1.2	1.2
Pennsylvania	1,992.8	1,813	23.8	39.2	37.0	35.8	64.2	75.0	21.7	0.0	0.4	2.9
Puerto Rico	155.9	89	44.5	54.5	1.0	40.2	59.8	20.0	20.0	20.0	20.0	20.0
Rhode Island	262.7	2,703	11.6	34.0	54.4	24.0	76.0	82.0	11.2	0.1	1.7	5.1
South Carolina	393.8	1,502	22.2	42.4	35.5	33.6	66.4	51.8	48.1	0.0	0.0	0.0
South Dakota	102.9	2,809	18.6	36.9	44.6	37.0	63.0	74.4	0.1	25.5	0.0	0.0
Tennessee	714.8	1,810	23.8	39.3	36.9	33.0	67.0	71.3	28.6	0.0	0.1	0.0
Texas	1,628.4	1,853	18.9	39.4	41.7	33.5	66.5	61.3	21.0	0.1	0.3	17.3
Utah	140.3	1,855	45.5	45.5	24.6	40.5	59.5	91.3	0.0	2.0	1.0	5.7
Vermont	94.6	1,891	44.0	44.0	39.1	34.8	65.2	93.9	1.3	1.6	3.2	0.0
Virgin Islands	4.1	295	45.0	42.9	12.1	33.8	66.2	20.0	20.0	20.0	20.0	20.0
Virginia	594.6	1,892	40.4	40.4	44.1	33.3	66.7	60.9	38.1	0.1	0.6	0.4
Washington	625.4	1,748	48.1	48.1	33.8	34.6	65.4	89.7	4.5	2.5	1.1	2.2
West Virginia	200.8	951	42.8	42.8	38.7	29.7	70.3	95.2	4.7	0.0	0.0	0.0
Wisconsin	919.7	2,246	37.4	37.4	48.5	35.7	64.3	91.2	6.0	1.2	0.5	1.0
Wyoming	32.8	1,563	29.0	29.0	49.5	25.7	74.3	90.3	2.0	1.3	0.2	6.2

[1] The race or ethnic origin of significant numbers of recipients in some reporting States was unknown. The Bureau of Data Management and Strategy estimated payments by race or ethnic origin for these States. Data by race or ethnic origin, therefore, should be used with caution.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 4.22

Percent distribution of Medicaid payments, by type of service and jurisdiction: Fiscal year 1986

Medicaid jurisdiction	Total payments in millions	Type of service: Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians'	Dental
		General hospital	Mental hospital		Mentally retarded	All other		
		Percent distribution						
All jurisdictions	$41,027.3	25.3	2.7	13.8	12.4	16.5	6.2	1.3
Alabama	409.6	19.6	0.6	2.7	12.1	30.1	9.2	0.9
Alaska	85.1	27.5	0.3	2.8	11.9	22.3	14.8	2.3
Arkansas	433.9	22.3	3.2	19.2	16.3	10.4	7.3	0.9
California	4,405.2	33.6	0.3	22.6	7.1	0.6	10.2	1.9
Colorado	300.2	10.5	2.6	49.7	0.0	0.0	7.2	0.5
Connecticut	675.3	18.3	4.2	5.5	11.8	40.1	3.4	0.6
Delaware	79.1	21.9	2.6	3.3	13.7	33.3	7.1	0.5
District of Columbia	201.3	0.9	8.0	2.4	15.6	32.9	9.9	0.5
Florida	1,003.3	26.1	0.8	6.0	12.3	30.3	3.5	0.8
Georgia	818.1	27.0	0.0	8.8	8.6	18.2	9.9	1.4
Hawaii	136.7	22.4	0.0	14.1	4.1	27.0	12.8	4.1
Idaho	85.5	18.3	0.0	11.5	19.9	27.2	7.9	0.8
Illinois	1,675.0	33.3	0.7	6.8	10.3	22.4	7.1	0.3
Indiana	828.4	21.9	0.7	10.5	5.1	32.4	8.3	1.6
Iowa	374.4	20.0	0.9	0.8	19.5	27.3	10.7	3.7
Kansas	238.5	15.3	4.3	0.8	19.5	34.0	7.5	1.8
Kentucky	536.6	26.2	2.0	6.5	7.2	22.0	12.3	1.4
Louisiana	779.6	21.5	1.6	0.6	18.3	26.1	6.9	1.1
Maine	282.8	26.8	0.0	1.3	9.3	34.2	5.4	0.7
Maryland	680.0	30.3	3.2	1.1	10.0	29.0	6.1	0.6
Massachusetts	1,664.8	30.4	0.4	12.7	14.5	15.8	3.1	1.1
Michigan	1,767.8	33.5	3.0	5.6	9.6	16.2	9.2	1.7
Minnesota	1,044.4	12.1	1.3	30.3	21.6	12.3	5.5	1.5
Mississippi	316.6	23.8	0.0	15.1	8.0	17.6	11.0	2.1
Missouri	555.8	20.8	1.2	1.6	8.1	39.5	7.2	1.6
Montana	112.0	22.8	0.0	1.1	8.3	38.5	7.8	2.2
Nebraska	187.5	21.7	1.6	6.0	13.0	30.4	8.9	1.6
Nevada	79.2	26.4	0.2	2.9	11.2	29.2	10.4	1.8
New Hampshire	133.1	11.7	3.5	0.6	8.7	50.0	2.7	0.3
New Jersey	1,281.4	24.7	4.7	3.0	14.0	26.2	3.6	1.6
New Mexico	164.8	29.2	0.0	1.0	12.1	25.4	10.3	1.7
New York	8,223.3	24.6	6.6	23.2	12.6	4.0	2.7	1.2
North Carolina	750.8	25.8	2.5	15.6	16.5	13.9	6.5	1.7
North Dakota	121.7	15.7	2.8	24.1	15.8	17.6	5.4	2.1
Ohio	2,049.5	27.9	0.6	19.2	12.4	12.7	5.6	1.4
Oklahoma	422.3	26.0	4.4	0.3	15.2	32.1	7.8	0.7
Oregon	260.4	13.2	2.3	1.9	20.0	28.0	6.5	1.0
Pennsylvania	1,992.8	21.2	5.0	5.6	17.4	28.4	3.8	1.3
Puerto Rico	155.9	35.8	0.0	0.0	0.0	0.0	0.0	0.0
Rhode Island	262.7	30.4	0.4	1.6	16.4	34.7	2.1	0.7
South Carolina	393.8	27.4	2.3	12.5	16.0	14.0	8.3	1.1
South Dakota	102.9	20.8	2.5	1.5	16.5	35.9	5.0	0.8
Tennessee	714.4	25.6	3.3	3.6	10.3	24.1	8.2	1.0
Texas	1,628.4	21.0	0.0	2.3	20.0	26.0	9.4	0.9
Utah	140.3	27.5	3.6	2.1	17.6	22.9	11.7	2.0
Vermont	94.6	17.7	0.7	1.1	14.1	32.1	7.0	0.8
Virgin Islands	4.1	38.6	0.0	0.0	0.0	0.0	2.0	2.9
Virginia	594.6	20.6	4.7	2.2	16.3	27.6	6.9	0.7
Washington	625.4	20.6	1.5	29.4	16.4	1.4	7.8	1.8
West Virginia	200.8	36.6	0.1	14.3	1.5	20.2	8.3	2.5
Wisconsin	919.7	12.2	1.5	32.6	8.1	18.2	3.7	1.0
Wyoming	32.8	30.0	0.8	6.0	0.0	43.6	10.0	2.7

See footnotes at end of table.

Table 4.22—Continued

Percent distribution of Medicaid payments, by type of service and jurisdiction: Fiscal year 1986

Medicaid jurisdiction	Type of service							
	Other practitioners'	Outpatient hospital	Clinic	Laboratory or radiological	Home health	Prescribed drugs	Family planning	Other
	Percent distribution							
All jurisdictions	0.6	4.8	2.0	1.0	3.3	6.6	0.5	3.0
Alabama	0.4	3.2	0.9	1.7	7.2	10.0	0.9	0.8
Alaska	1.0	8.4	3.3	0.1	0.1	0.0	0.4	4.6
Arkansas	0.4	1.5	2.3	0.8	1.2	11.0	0.1	3.2
California	1.1	5.2	2.9	2.1	0.2	7.7	0.6	4.0
Colorado	0.2	5.3	3.4	0.3	1.2	6.2	0.4	12.4
Connecticut	0.5	5.4	0.8	0.2	1.8	4.9	0.3	2.2
Delaware	0.3	6.8	0.1	0.2	3.5	5.1	1.3	0.4
District of Columbia	0.2	8.6	7.7	0.5	4.8	5.1	0.2	2.7
Florida	0.3	3.2	1.4	0.8	2.2	10.1	0.1	2.2
Georgia	0.4	6.0	1.7	0.1	2.4	11.5	1.1	2.9
Hawaii	0.8	4.2	0.4	1.3	0.3	6.5	0.7	1.3
Idaho	0.8	4.0	1.1	1.2	2.0	2.5	0.3	2.4
Illinois	0.6	3.4	1.1	1.4	2.6	7.7	0.7	1.7
Indiana	0.7	4.5	0.8	0.1	0.5	7.9	0.7	4.2
Iowa	1.0	4.4	0.4	0.2	1.0	7.5	1.1	1.6
Kansas	0.5	2.8	1.7	0.7	0.7	7.2	0.7	2.6
Kentucky	0.5	5.2	3.9	0.1	5.0	6.3	0.8	0.8
Louisiana	0.1	3.4	1.3	4.5	0.6	10.2	0.7	2.9
Maine	0.9	6.2	1.3	0.1	4.9	6.5	0.5	2.0
Maryland	0.1	6.9	1.0	0.4	2.0	6.0	1.0	2.3
Massachusetts	0.6	7.4	2.9	0.2	3.4	4.6	0.3	2.7
Michigan	0.6	5.7	0.1	1.0	0.4	6.5	1.3	5.6
Minnesota	0.9	2.4	0.1	0.1	2.5	4.4	0.3	4.9
Mississippi	0.3	5.5	0.0	0.4	0.8	13.1	0.8	1.5
Missouri	0.6	5.5	3.5	0.4	1.0	7.2	0.6	1.1
Montana	1.8	3.4	1.7	0.2	0.3	5.9	0.8	5.1
Nebraska	1.1	3.0	0.2	1.1	1.1	8.4	0.4	1.6
Nevada	0.5	3.9	0.1	0.5	3.4	5.3	0.6	3.6
New Hampshire	0.2	2.5	2.5	0.1	10.4	4.9	0.3	1.6
New Jersey	0.5	5.8	4.3	0.5	2.0	6.9	0.5	1.6
New Mexico	0.7	5.3	0.4	0.4	1.6	8.0	0.8	3.2
New York	0.7	4.5	2.5	0.8	9.3	4.5	0.3	2.6
North Carolina	0.4	3.0	1.3	1.6	2.7	7.5	0.6	0.6
North Dakota	0.6	2.0	1.1	0.3	5.0	5.3	0.3	2.0
Ohio	0.7	6.4	1.5	1.2	0.1	6.2	0.5	3.4
Oklahoma	0.2	1.2	0.3	0.0	0.0	3.1	0.1	8.6
Oregon	0.3	4.1	2.9	2.5	4.0	7.3	0.9	5.1
Pennsylvania	0.3	2.6	2.9	0.8	0.3	6.8	0.6	3.1
Puerto Rico	0.0	64.2	0.0	0.0	0.0	0.0	0.0	0.0
Rhode Island	0.2	4.1	0.0	0.1	2.8	5.1	0.2	1.2
South Carolina	0.2	4.0	1.4	0.2	2.2	7.6	0.7	2.3
South Dakota	0.2	2.7	0.7	1.1	6.2	4.4	0.2	1.3
Tennessee	0.2	5.5	3.8	1.8	1.0	9.6	0.8	1.2
Texas	0.8	3.4	0.0	2.3	5.6	6.8	0.6	1.0
Utah	0.8	2.9	0.5	0.2	0.4	6.0	0.5	1.3
Vermont	0.4	4.0	11.6	0.1	2.0	7.2	0.4	0.6
Virgin Islands	0.0	40.4	0.0	0.6	0.0	10.8	1.0	3.7
Virginia	0.2	5.5	1.2	0.7	2.7	8.4	0.4	1.8
Washington	0.9	4.1	2.6	1.5	1.0	5.7	0.5	4.9
West Virginia	1.0	2.2	0.5	0.6	0.6	7.9	0.4	3.3
Wisconsin	0.4	4.1	2.4	1.5	2.6	6.0	0.6	4.8
Wyoming	0.6	4.3	0.0	0.4	0.7	0.0	0.6	0.2

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 4.23

Percent distribution of Medicaid payments, by age, sex, race or ethnic origin, and type of service: Fiscal year 1986

Type of service	Payments in millions	Age				Sex		Race or ethnic origin[1]				
		Under 6 years	6-20 years	21-64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
		Percent of payments										
All services	$41,027.3	8.1	11.5	41.1	39.3	34.5	65.5	72.2	21.0	0.9	1.4	4.5
Inpatient hospital	11,481.0	16.4	16.5	43.8	23.2	37.4	62.6	58.6	31.0	1.3	1.7	7.4
Skilled nursing facility	5,655.7	1.4	1.8	19.2	77.6	26.2	73.8	90.5	7.1	0.2	0.8	1.4
Intermediate care facility[2]	11,861.6	0.5	5.9	42.4	51.2	38.8	61.2	86.1	11.4	0.6	0.9	1.4
Physicians'	2,548.2	16.3	20.5	50.8	12.3	30.2	69.8	60.1	27.5	1.1	2.3	9.0
Dental	531.9	11.2	42.9	37.8	8.1	34.8	65.2	60.0	26.0	1.2	2.9	10.0
Other practioners'	251.6	7.5	27.7	46.9	17.8	32.2	67.8	66.7	23.0	1.1	1.8	7.3
Outpatient hospital	1,982.9	16.9	22.5	52.3	8.3	34.6	65.4	55.7	31.6	2.2	2.4	8.1
Clinic	810.0	8.9	19.2	62.4	9.5	42.1	57.9	65.1	27.9	0.8	1.1	5.1
Laboratory and radiological	424.4	10.0	19.8	62.0	8.2	26.0	74.0	54.5	32.1	0.8	2.0	10.5
Home health	1,352.1	2.5	2.5	31.6	63.3	25.2	74.8	70.4	25.4	0.5	0.7	3.0
Prescribed drugs	2,691.9	5.5	7.7	44.3	42.5	28.4	71.6	69.5	23.9	0.5	1.7	4.4
Family planning	225.6	0.0	20.8	79.2	0.0	1.2	98.8	50.2	39.1	0.9	1.4	8.5
Other	1,210.5	13.9	18.2	41.1	26.8	40.0	60.0	62.6	29.2	1.3	1.3	5.5

[1] The race of ethnic origin of significant numbers of recipients in some reporting States are unknown. The Bureau of Data Management and Strategy estimated payments by race or ethnic origin for these States. Data by race or ethnic origin, therefore, should be used with caution.

[2] Figures include intermediate care facilities (ICFs) for mentally retarded and all other ICFs. Expenditures within the category of 21-64 years reflect mainly use of ICFs for the mentally retarded. Expenditures within the age category of 65 years or over reflect mainly use of all other ICFs.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Other data on payments

Per capita personal income, percent of population below the poverty level (as defined by the Census Bureau), and average payment per Medicaid recipient are presented in Table 4.24. Average payment per Medicaid recipient ranged from a low of $951 in West Virginia to $3,765 in New Hampshire.

Federal and State payments for medical assistance and administration and training by jurisdiction are presented in Table 4.25. These payment data may differ from payment data presented in other tables because these data reflect accounting adjustments, such as changes in payments to cost-reimbursed providers following year-end audits.

Overall, 95.2 percent of all Medicaid payments were for medical assistance, of which 55.6 percent was paid by the Federal Government and 44.4 percent by the States. Only 4.8 percent of Medicaid payments were for administration and training, of which 58.8 percent was paid by the Federal Government and 41.2 percent by the States (derived from table).

Provider participation in Medicaid

Brief information is presented in this section on provider participation in Medicaid, including physicians, inpatient hospitals, and long-term-care facilities.

The number of enrolled and participating physicians in Medicaid by State are shown in Table 4.26. Enrolled physicians generally are defined as physicians who have applied for and received a Medicaid provider number. Providers are certified as enrolled regardless of their participation status. Participating physicians thus are defined as enrolled physicians who have submitted at least one claim within the past 12-month period. It is important to note that in some States these counts include only individual physicians but in others the counts include individual physicians and group practices. In the latter case, a group practice of 20 physicians may be reported as a single physician provider. In addition, in some States a physician can have more than one provider number and thus may be counted more than once in the counts of enrolled and participating physicians. The data presented, therefore, should be used with caution.

Table 4.24

Per capita personal income, percent of population below the poverty level, and payment per Medicaid recipient, by State: Fiscal year 1986

State	Per capita personal income	Percent of population below poverty level[1]	Payment per Medicaid recipient	State	Per capita personal income	Percent of population below poverty level[1]	Payment per Medicaid recipient
U.S. average	$14,606	14.0	$1,822	Montana	11,726	16.3	2,145
Alabama	11,293	21.5	1,295	Nebraska	13,572	14.6	1,838
Alaska	18,378	10.4	2,965	Nevada	15,453	12.4	2,435
Arkansas	11,025	22.4	2,134	New Hampshire	16,396	5.6	3,765
California	16,792	13.4	1,271	New Jersey	18,793	9.5	2,205
Colorado	15,114	10.8	2,014	New Mexico	11,459	20.7	1,794
Connecticut	19,547	7.2	3,117	New York	16,821	15.2	3,541
Delaware	15,498	11.3	2,014	North Carolina	12,423	14.0	1,985
District of Columbia	18,876	19.2	2,053	North Dakota	12,440	14.9	3,030
Florida	14,622	13.3	1,707	Ohio	13,857	12.4	1,900
Georgia	13,454	15.6	1,692	Oklahoma	12,249	15.5	1,743
Hawaii	14,683	9.9	1,537	Oregon	13,239	12.6	1,602
Idaho	11,172	16.4	2,121	Pennsylvania	14,281	12.4	1,813
Illinois	15,503	15.0	1,575	Rhode Island	14,589	11.2	2,703
Indiana	13,124	12.2	2,782	South Carolina	11,286	17.6	1,502
Iowa	13,335	16.5	1,687	South Dakota	11,803	16.2	2,809
Kansas	14,503	11.2	1,820	Tennessee	11,984	17.8	1,810
Kentucky	11,268	18.5	1,293	Texas	13,494	16.2	1,853
Louisiana	11,233	20.8	1,746	Utah	10,968	11.9	1,855
Maine	12,846	11.1	2,261	Vermont	13,320	10.2	1,891
Maryland	16,934	8.5	2,103	Virginia	15,423	10.6	1,892
Massachusetts	17,635	8.8	3,148	Washington	14,866	11.7	1,748
Michigan	14,807	14.4	1,579	West Virginia	10,587	22.8	951
Minnesota	14,995	11.5	3,032	Wisconsin	13,923	11.8	2,246
Mississippi	9,963	25.6	993	Wyoming	12,723	12.3	1,563
Missouri	13,946	14.3	1,544				

[1] Mid-1980s data, (1984, 1985, 1986).

SOURCES: Per capita income: Department of Commerce, Bureau of Economic Analysis. Poverty population: Plotnick, R., and Danziger, S.: Poverty rates by State in the mid-1980s: An update. *Focus* 11(3):12-14, 1988. Payment per recipient: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 4.25

Medicaid payments eligible for Federal financial participation, by type of payment and jurisdiction: Fiscal year 1986

Medicaid jurisdiction	All payments	Type of payment					
		Medical assistance			Administration and training		
		Total computable	Federal share	State share	Total computable	Federal share	State share
		Amount in millions					
United States	$44,403.9	$42,260.8	$23,482.7	$18,778.1	$2,143.1	$1,260.1	$883.0
Alabama	442.6	427.3	309.6	117.7	15.3	10.0	5.3
Alaska	87.0	82.5	43.1	39.4	4.5	2.5	2.0
American Samoa	3.2	3.2	1.2	2.0	0.0	0.0	0.0
Arizona	115.3	101.7	66.4	35.3	13.6	7.0	6.6
Arkansas	423.4	404.6	299.0	105.6	18.8	12.3	6.5
California	5,057.5	4,756.2	2,382.3	2,373.9	301.3	177.9	123.4
Colorado	331.3	314.1	157.2	156.9	17.2	10.0	7.2
Connecticut	703.8	672.7	336.9	335.8	31.1	17.5	13.6
Delaware	84.4	80.8	40.9	39.9	3.6	1.9	1.7
District of Columbia	329.8	311.8	156.3	155.5	18.0	10.5	7.5
Florida	1,066.8	1,023.0	574.8	448.2	43.8	25.3	18.5
Georgia	859.0	820.6	542.2	278.4	38.4	22.4	16.0
Guam	3.5	3.1	1.5	1.6	0.4	0.2	0.2
Hawaii	149.2	140.1	71.9	68.2	9.1	5.6	3.5
Idaho	86.8	82.0	57.0	25.0	4.8	3.1	1.7
Illinois	1,813.0	1,736.5	873.7	862.8	76.5	43.2	33.3
Indiana	890.5	861.8	542.7	319.1	28.7	15.6	13.1
Iowa	393.0	377.7	223.3	154.4	15.3	9.5	5.8
Kansas	286.7	274.0	137.6	136.4	12.7	7.9	4.8
Kentucky	585.5	557.1	392.1	165.0	28.4	17.5	10.9
Louisiana	836.7	805.5	515.3	290.2	31.2	18.3	12.9
Maine	271.0	258.0	178.9	79.1	13.0	7.9	5.1
Maryland	744.1	709.1	356.9	352.2	35.0	19.7	15.3
Massachusetts	1,711.5	1,644.9	823.8	821.1	66.6	37.2	29.4
Michigan	1,869.8	1,774.5	1,015.0	759.5	95.3	56.0	39.3
Minnesota	1,082.5	1,029.7	551.4	478.3	52.8	28.9	23.9
Mississippi	348.6	337.4	264.2	73.2	11.2	7.0	4.2
Missouri	596.7	572.8	348.2	224.6	23.9	13.7	10.2
Montana	123.5	116.3	77.9	38.4	7.2	4.9	2.3
Nebraska	201.1	188.9	108.2	80.7	12.2	7.1	5.1
Nevada	85.4	79.4	40.0	39.4	6.0	3.3	2.7
New Hampshire	152.7	142.7	78.8	63.9	10.0	6.5	3.5
New Jersey	1,356.6	1,285.3	646.1	639.2	71.3	45.9	25.4
New Mexico	180.6	171.5	119.6	51.9	9.1	5.9	3.2
New York	8,667.1	8,292.1	4,157.8	4,134.8	375.0	224.6	150.4
North Carolina	792.8	756.4	524.6	231.8	36.4	20.0	16.4
North Dakota	126.3	118.4	65.2	53.2	7.9	4.6	3.3
Northern Mariannas	1.1	1.0	0.5	0.5	0.1	0.0	0.1
Ohio	2,088.8	2,021.2	1,187.9	833.3	67.6	39.5	28.1
Oklahoma	519.4	479.6	277.1	202.5	39.8	21.5	18.3
Oregon	308.4	272.1	168.9	103.2	36.3	22.0	14.3
Pennsylvania	2,262.1	2,158.3	1,228.8	929.5	103.8	58.3	45.5
Puerto Rico	146.6	132.9	57.8	75.1	13.7	5.6	8.1
Rhode Island	279.5	271.5	153.1	118.4	8.0	4.1	3.9
South Carolina	423.3	400.6	291.3	109.3	22.7	13.3	9.4
South Dakota	105.9	103.4	71.3	32.1	2.5	1.6	0.9
Tennessee	763.7	730.4	513.4	217.0	33.3	21.0	12.3
Texas	1,667.5	1,551.6	833.5	718.1	115.9	71.8	44.1
Utah	199.8	184.7	134.3	50.4	15.1	9.4	5.7
Vermont	102.4	94.1	63.3	30.8	8.3	5.2	3.1
Virgin Islands	4.7	4.2	1.8	2.4	0.5	0.3	0.2
Virginia	647.2	612.3	326.2	286.1	34.9	19.5	15.4
Washington	698.0	653.8	329.4	324.4	44.2	24.9	19.3
West Virginia	222.4	211.8	151.6	60.2	10.6	7.0	3.6
Wisconsin	1,069.5	1,030.7	594.9	435.8	38.8	23.0	15.8
Wyoming	34.3	32.9	16.5	16.4	1.4	0.7	0.7

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from the Division of Financial Management.

Table 4.26

Enrolled and participating physicians, by State

State	Number of physicians		File based on:		Date of last file update
	Enrolled	Participating	Individuals	Individuals and groups	
Alabama	9,688	9,688	Y	N	1985
Alaska	450	—	Y	N	1984
Arkansas	4,615	1,063	N	Y	1985
California	45,845	31,703	N	Y	1986
Colorado	6,922	—	N	Y	—
Connecticut	4,791	2,594	N	Y	1981
Delaware	1,100	1,100	Y	N	—
District of Columbia	4,022	1,812	N	Y	1981
Florida	18,190	14,104	N	Y	1985
Georgia	8,500	8,500	Y	N	1986
Hawaii	2,570	2,570	N	Y	1985
Idaho	4,112	1,617	N	Y	1985
Illinois	22,282	16,055	Y	N	1986
Indiana	12,726	7,225	N	Y	1984
Iowa	6,592	4,927	N	Y	1986
Kansas	8,729	4,611	N	Y	1985
Kentucky	15,221	2,537	N	Y	—
Louisiana	8,285	3,994	N	Y	1986
Maine	3,253	1,619	N	Y	—
Maryland	13,220	4,968	N	Y	1982
Massachusetts	11,580	11,580	Y	N	1986
Michigan	19,453	—	N	Y	1981
Minnesota	13,079	8,351	N	Y	1986
Mississippi	6,119	4,290	Y	N	1984
Missouri	14,327	5,730	N	Y	—
Montana	1,528	1,528	Y	N	1985
Nebraska	2,023	1,062	N	Y	1986
Nevada	1,700	1,650	N	Y	1986
New Hampshire	2,356	481	N	Y	1985
New Jersey	9,356	4,650	N	Y	1985
New Mexico	3,822	1,629	N	Y	1984
New York	43,811	38,496	N	Y	1986
North Carolina	6,000	2,300	N	Y	1983
North Dakota	1,955	609	N	Y	1985
Ohio	27,478	23,378	N	Y	1985
Oklahoma	10,000	10,000	Y	N	—
Oregon	9,526	5,239	N	Y	1986
Pennsylvania	24,645	17,498	N	Y	—
Rhode Island	1,657	1,657	N	Y	1986
South Carolina	5,550	3,879	N	Y	—
South Dakota	2,777	1,229	N	Y	1986
Tenessee	10,646	5,507	N	Y	1981
Texas	22,781	17,776	N	Y	1986
Utah	3,313	2,159	N	Y	1985
Vermont	2,800	2,400	N	Y	1985
Virginia	9,269	7,658	Y	N	1986
Washington	12,295	5,429	N	Y	1985
West Virginia	4,753	3,493	N	Y	1986
Wisconsin	12,303	6,067	N	Y	1986
Wyoming	1,130	1,130	N	Y	—

NOTES: Y is yes; N is no. In many States, the physician counts cited in this table are counts of the number of unique physician identification numbers. In a number of States, these counts do not necessarily reflect the actual number of individual physicians enrolled or participating in Medicaid because some States assign a single identification number to group practices and a single physician can have more than one identification number. Therefore, these counts should be interpreted with caution.

SOURCE: (Health Care Financing Administration, 1987).

The number of Medicaid-certified beds in general hospitals, SNFs, ICFs, and ICFs/MR are presented in Table 4.27. As of March 1986, there were 899,946 Medicaid-certified inpatient beds across all jurisdictions. The smallest number of general hospital beds was reported in Wyoming with 457 and the largest was in California with 92,775. The number of SNF Medicaid-certified beds ranged from 0 in 9 States to 44,664 in Wisconsin, and the number of dually-certified SNF beds ranged from 0 in Oklahoma to 84,148 in New York. There was a total of 447,854 Medicaid-certified ICF beds, ranging from 41 in Alaska to 71,221 in Texas. There were 149,217 ICF/MR beds across all jurisdictions, ranging from 0 in Wyoming to 16,995 in New York. Finally, Medicaid-certified SNF-ICF beds were reported by only 5 States with Florida having the largest number at 27,367, and dually certified SNF-ICF beds ranged from 0 in 10 States to 47,606 in Wisconsin.

Medicaid data system

In most States the Medicaid Management Information System (MMIS) is central to State Medicaid data processing activities. MMIS is a general conceptual design for automated claims processing and information retrieval. States are free to tailor the system to their particular needs as long as the system meets federally required minimum performance standards. The general MMIS design includes six subsystems: recipient, provider, claims processing, reference file, management and administration reporting (MARS), and surveillance and utilization review (SURS). The first four subsystems related to the claims processing function of the agency, MARS relates to the program control function, and SURS focuses on the program control and program integrity functions. As of March 1986, 44 States had certified MMIS systems in operation (only Alaska, Delaware, Nevada, Rhode Island, Tennessee, and Wyoming did not).

As part of MARS processing within the MMIS system, States must generate and submit to HCFA a yearly report entitled, "Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services" (also referred to as the HCFA-2082 report). This report provides data, aggregated to the State level, on utilization of and payments for Medicaid services. (Note that States without a certified MMIS system also must generate a HCFA-2082 report from their claims processing and payment systems.) The majority of the data on utilization and payments presented in this chapter came from the HCFA-2082 reports submitted by the States.

Recall that States tailor their MMIS systems to meet their particular needs. This flexibility reflects the program diversity existing among the States. However, creating standardized reports from systems employing nonstandard coding, processing, and file structures, is obviously difficult. Compounding this difficulty is the programmatic diversity inherent in Medicaid itself. For example, the cross-county variation inherent in the New York State program leads to considerable problems in the creation of a State-level report. As a consequence of these and other factors, approximately six States do not file an annual report in any year. Historically, data for nonreporting States have been estimated using weighted linear extrapolation methods and aggregating data from other reports. It also should be noted that, on several occasions, information supplied by the States in subsequent years has been used to refine or correct data for previous years or provide missing data. Hence, data contained in this report may differ from those published previously.

Special topic: Maternal and child health expansions

Introduction

Maternal and child health is a significant issue and the struggle continues in trying to improve health outcomes for these groups. For example, an important indicator of the Nation's health status is the infant mortality rate. As shown in Table 4.28, from 1970 to 1980 improvements occurred in the overall U.S. infant mortality rate, with the rate decreasing from 20.0 deaths per 1,000 live births to 12.6 deaths per 1,000 live births. After 1980, however, the pace of improvement in the Nation's infant mortality rate slowed, decreasing only to a rate of 10.4 deaths per 1,000 live births by 1986. This rate placed the United States eighteenth worldwide among industrialized nations in terms of infant mortality.

The problem is especially pronounced for minority races. In 1986, the mortality rate for black infants, 18.0 deaths per 1,000 live births, was approximately twice the rate for white infants, 8.9 deaths per 1,000 live births. The 1986 black-white infant mortality gap is greater than that of 1940 when infant mortality data were first reported by race.

Recent legislative changes in Medicaid

In order to address the health care needs of our Nations's low-income women, children, and infants, Congress has passed legislation that expands and enhances Medicaid maternal and child health services. The 1980s were marked by a series of legislative changes in the Medicaid program pertaining to these groups. These legislative expansions were characterized by a philosophical shift from the traditional Medicaid eligibility requirements. Medicaid eligibility was expanded to improve the access of low-income women, children, and infants to needed health care by not only broadening the allowable service coverage to these groups but also severing the traditional link between Medicaid and AFDC income eligibility criteria.

The first legislation of this nature was the Omnibus Reconciliation Act (ORA) of 1980 (Public Law 96-499). ORA mandated Medicaid coverage of services furnished by licensed nurse-midwives.

The Omnibus Budget Reconciliation Act (OBRA) of 1981 was the first departure from traditional Medicaid eligibility. OBRA 1981 granted States the option of providing Medicaid coverage to children not eligible for

Table 4.27

Medicaid-certified beds, by type of provider and State: March 1986

State	Certified beds							
			SNF[1]		ICF[2]		SNF-ICF	
	General hospital	Swing-beds	Medicaid-certified	Dually certified[3]	ICF other than for mentally retarded	ICF for mentally retarded	Medicaid certified	Dually certified[3]
United States	899,946	9,179	376,326	438,242	447,854	149,217	72,450	501,742
Alabama	21,424	—	4,403	10,571	1,135	1,419	0	6,466
Alaska	1,123	0	395	184	41	104	0	579
Arkansas	—	219	13,493	1,395	6,402	1,529	0	0
California	92,775	250	35,862	66,262	2,534	9,596	0	7,582
Colorado	12,914	225	9,357	2,499	1,440	1,318	0	11,856
Connecticut	10,510	0	2,159	18,803	2,249	1,474	—	19,604
Delaware	—	—	209	1,321	434	474	0	983
District of Columbia	5,456	0	0	420	802	341	0	262
Florida	—	—	29,443	15,751	158	3,261	27,367	45,173
Georgia	25,960	0	23,500	6,296	2,715	2,240	0	27,514
Hawaii	—	—	243	1,786	780	378	0	1,384
Idaho	3,449	13	2,000	2,783	84	536	0	4,783
Illinois	60,479	768	41,917	7,160	23,955	8,138	0	45,843
Indiana	24,896	0	1,454	9,936	22,526	3,835	0	3,857
Iowa	14,800	400	67	844	30,379	1,339	0	324
Kansas	—	64	2,258	810	20,622	2,231	—	2,100
Kentucky	18,786	8	6	3,624	9,459	1,203	0	42
Louisiana	22,810	153	212	3,130	28,783	6,129	0	1,329
Maine	5,138	0	58	370	7,719	834	0	0
Maryland	20,043	0	0	10,544	7,047	2,256	0	10,544
Massachusetts	28,294	0	16,195	6,785	10,924	4,036	0	41
Michigan	[4]39,745	0	12,191	23,250	9,739	4,091	0	33,283
Minnesota	20,416	332	25,313	11,993	7,003	7,817	—	24,352
Mississippi	15,730	1,148	11,534	349	1,183	1,572	9,830	8,840
Missouri	31,764	224	16,091	4,444	9,369	1,841	22,321	20,391
Montana	—	211	1,955	2,204	756	316	0	4,159
Nebraska	6,021	1,860	2,415	1,097	12,631	855	2,242	2,722
Nevada	6,315	100	0	2,264	182	187	0	2,163
New Hampshire	3,547	276	202	440	4,723	377	0	0
New Jersey	30,031	0	20,451	13,427	1,636	3,881	—	33,771
New Mexico	5,005	151	0	397	3,712	704	0	0
New York	73,039	0	313	84,148	5,524	16,995	0	0
North Carolina	28,487	528	10,554	9,510	11,878	3,139	0	0
North Dakota	4,077	1,013	1,301	3,467	1,450	857	0	4,768
Ohio	50,206	0	0	39,997	29,366	8,078	0	36,222
Oklahoma	19,500	0	106	0	28,330	3,206	0	0
Oregon	8,213	0	748	1,089	6,868	2,131	0	47
Pennsylvania	66,451	0	10,666	27,740	10,680	8,358	0	37,736
Rhode Island	4,748	0	0	2,363	7,141	1,019	0	0
South Carolina	11,565	0	92	8,211	1,828	2,751	0	8,087
South Dakota	3,831	314	4,656	322	2,459	806	0	4,978
Tennessee	27,156	0	0	4,610	17,745	1,565	0	2,617
Texas	—	0	5,334	7,546	71,221	14,410	0	9,577
Utah	5,100	350	0	4,280	1,472	1,304	0	0
Vermont	2,601	20	63	592	1,286	271	0	0
Virginia	20,175	0	0	2,186	10,627	3,167	0	88
Washington	12,481	105	22,691	2,352	1,112	2,835	10,690	25,058
West Virginia	10,734	0	88	3,084	4,741	109	0	3,136
Wisconsin	23,694	—	44,664	5,398	2,642	3,904	0	47,606
Wyoming	457	447	1,667	208	362	0	0	1,875

[1] SNF is skilled nursing facility.
[2] ICF is intermediate care facility.
[3] Certified by Medicare and Medicaid.
[4] Excludes State and Federal institutions.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 4.28

Infant mortality rates,[1] by race: United States, 1940-86

Year	All races	White	Minorities		Ratio of black to white
			Black	Total	
1940	47.0	43.2	72.9	73.8	1.69
1941	45.3	41.2	74.1	74.8	1.80
1942	40.4	37.3	64.2	64.6	1.72
1943	40.4	37.5	61.5	62.5	1.64
1944	39.8	36.9	59.3	60.3	1.61
1945	38.3	35.6	56.2	57.0	1.58
1946	33.8	31.8	48.8	49.5	1.53
1947	32.2	30.1	47.7	48.5	1.58
1948	32.0	29.9	45.7	46.5	1.58
1949	31.3	28.9	46.8	47.3	1.62
1950	29.2	26.8	43.9	44.5	1.64
1951	28.4	25.8	44.3	44.8	1.72
1952	28.4	25.5	46.9	47.0	1.84
1953	27.8	25.0	44.5	44.7	1.78
1954	26.6	23.9	42.9	42.9	1.79
1955	26.4	23.6	43.1	42.8	1.83
1956	26.0	23.2	42.4	42.1	1.83
1957	26.3	23.3	44.2	43.7	1.90
1958	27.1	23.8	46.3	45.7	1.95
1959	26.4	23.2	44.8	44.0	1.93
1960	26.0	22.9	44.3	43.2	1.93
1961	25.3	22.4	41.8	40.7	1.87
1962	25.3	22.3	42.6	41.4	1.91
1963	25.2	22.2	42.8	41.5	1.93
1964	24.8	21.6	42.3	41.1	1.96
1965	24.7	21.5	41.7	40.3	1.94
1966	23.7	20.6	40.2	38.8	1.95
1967	22.4	19.7	37.5	35.9	1.90
1968	21.8	19.2	36.2	34.5	1.89
1969	20.9	18.4	34.8	32.9	1.89
1970	20.0	17.8	32.6	30.9	1.83
1971	19.1	17.1	30.3	28.5	1.77
1972	18.5	16.4	29.6	27.7	1.80
1973	17.7	15.8	28.1	26.2	1.78
1974	16.7	14.8	26.8	24.9	1.81
1975	16.1	14.2	26.2	24.2	1.85
1976	15.2	13.3	25.5	23.5	1.92
1977	14.1	12.3	23.6	21.7	1.92
1978	13.8	12.0	23.1	21.1	1.93
1979	13.1	11.4	21.8	19.8	1.91
1980	12.6	11.0	21.4	19.1	1.95
1981	11.9	10.5	20.0	17.8	1.90
1982	11.5	10.1	19.6	17.3	1.94
1983	11.2	9.7	19.2	16.8	1.98
1984	10.8	9.4	18.4	16.1	1.96
1985	10.6	9.3	18.2	15.8	1.96
1986	10.4	8.9	18.0	15.7	2.02

[1]Deaths per 1,000 live births.

SOURCE: National Center for Health Statistics: *Health, United States, 1988.* DHHS Pub. No. (PHS)89-1232. Public Health Service. Washington. U.S. Government Printing Office, Mar. 1989.

AFDC due to living in two-parent families. However, these children had to satisfy the AFDC income and resources requirements. This group of children is known as "Ribicoff children." States have the option to limit Medicaid coverage to Ribicoff children under age 18, 19, 20, or 21 (as determined by the State).

OBRA 1981 required that States with medically needy programs provide, at a minimum, ambulatory services to children and prenatal and delivery services to pregnant women.

In addition, OBRA 1981 created the home and community-based waiver program through which specified groups could receive needed health care. The home and community-based waiver program allows States the option of providing Medicaid services (not covered in the their State plan) in the community to persons who otherwise would be institutionalized.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 enabled States to provide Medicaid coverage to disabled children under 19 years of age who live at home and who are not otherwise eligible for Medicaid but who would be eligible for Medicaid if receiving care in an institution. To provide coverage to this group, States must determine that institutional care would have been required, that home care is appropriate, and that the estimated cost of home care is no more than institutional care.

The Deficit Reduction Act (DEFRA) of 1984 (Public Law 98-369) extended the OBRA 1981 provisions by mandating Medicaid coverage to Ribicoff children under 5 years of age, born after September 30, 1983, phased in over a five-year period.

DEFRA also required States to provide Medicaid coverage to the following two groups of women: pregnant women in two-parent families with an unemployed principal breadwinner, and first-time pregnant women who would be eligible for AFDC if the child were born. As with Ribicoff children, these two groups of women were not eligible for Medicaid prior to DEFRA because of their family structure. However, as with Ribicoff children, both of these groups of women must meet AFDC income and resources requirements.

In addition, DEFRA required States to automatically extend Medicaid eligibility for 1 year to infants born after October 1, 1984, to women who were eligible for and receiving Medicaid at the time of the child's birth. Thus for 1 year after birth, the child remains eligible as long as the mother remains eligible.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Public Law 99-272) extended the DEFRA mandatory provisions for pregnant women by requiring States to provide Medicaid coverage of prenatal and delivery services to all pregnant women in two-parent families who meet AFDC income and resources requirements.

Also mandated was an extension of the postpartum coverage of Medicaid-eligible pregnant women to the end of the 60-day period beginning on the last day of their pregnancy.

COBRA 1985 enables States to target pregnancy-related services to pregnant women. Optional Medicaid services were extended to include case-management services that could be targeted to particular groups. Moreover, States were allowed to extend immediate Medicaid eligibility to children under 5 years of age who meet AFDC income and resources requirements rather than having to phase in this coverage as required by DEFRA 1984.

The COBRA 1985 legislation was followed by implementation of the Omnibus Budget Reconciliation Act (OBRA) of 1986 (Public Law 99-509). OBRA 1986 severed the link between Medicaid eligibility and eligibility for AFDC for certain groups. Specifically, States were allowed to offer Medicaid coverage to all pregnant women (limited to pregnancy-related services),

infants up to 1 year of age, and children up to 5 years of age (phased in over a five-year period), with incomes up to 100 percent of poverty. Other major optional provisions of OBRA 1986 were: presumptive eligibility, which allowed specific primary care providers to authorize short-term Medicaid eligibility status for pregnant women; continuous eligibility, whereby pregnant women who are eligible for Medicaid at some time during their pregnancies, regardless of changes in their eligibility status, could be granted continuous coverage for up to 60 days postpartum; and waiving the assets test, which allowed financial eligibility for pregnant women and for infants to be based upon income only.

Furthermore, OBRA 1986 required States to extend eligibility for emergency services, including emergency labor and delivery, to illegal aliens.

The Omnibus Budget Reconciliation Act (OBRA) of 1987 (Public Law 100-203) mandated Medicaid coverage to children up to 7 years of age (who meet the AFDC income and resources requirements) by October 1, 1989. States also had the option of extending such coverage to children up to 8 years of age.

OBRA 1987 further extended the income eligibility expansions by allowing States a number of options in providing services to pregnant women and to children. First, States were allowed to extend Medicaid coverage to pregnant women and to infants under 1 year of age in families with incomes up to 185 percent of poverty. In addition, States were allowed to enhance the OBRA 1986 provision by providing immediate coverage of children up to 2, 3, 4, or 5 years of age (as determined by the State) with family incomes up to 100 percent of poverty. Finally, postpartum coverage, legislated in COBRA 1985, was extended to the end of the month in which the 60-day postpartum period ends.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 (Public Law 100-360) mandated the optional eligibility income provisions for pregnant women and for children legislated in OBRA 1986. States were required to provide Medicaid coverage, on a phased-in basis, to pregnant women and to infants up to age 1 with incomes up to 100 percent of poverty. This legislation would be phased in requiring coverage of individuals in families with incomes at or below 75 percent of poverty effective July 1, 1989, and those with incomes at or below 100 percent of poverty beginning July 1, 1990. (Note that although the MCCA was subsequent repealed, these Medicaid provisions were enacted.)

The Family Support Act of 1988 (Public Law 100-485) mandated AFDC-UP coverage for two-parent families when the principal breadwinner is unemployed. Although not specifically labeled as Medicaid legislation, because of the eligibility link between AFDC and Medicaid, Medicaid coverage also was mandated for this specific group.

The Omnibus Reconciliation Act (OBRA) of 1989 (Public Law 101-239) required States to extend Medicaid coverage to all pregnant women and to children up to 6 years of age in families whose incomes are below 133 percent of the Federal poverty level. It also gave States the option to extend coverage to children age 6-8 in families below 100 percent of the poverty level.

State activities

State activities in enacting selected recent coverage options for pregnant women and for children are summarized in Table 4.29. As of September 1989, 15 States extended Medicaid eligibility thresholds for pregnant women and for infants to the allowable limit of 185 percent of poverty. (Note that in July 1989, Medicaid coverage was mandatory only for pregnant women and for infants in families whose income was below 75 percent of the poverty level. Effective April 1, 1990, coverage of this group is mandatory up to 133 percent of the poverty level.) Forty-two States no longer required an assets test for Medicaid eligibility for pregnant women, 41 States implemented continuous eligibility provisions, and 23 States implemented presumptive eligibility provisions.

Table 4.29

Coverage options for children and pregnant women, by State: September 1989

State	Infants and pregnant women under percent of poverty[1]	Eliminated assets test	Continuous eligibility	Presumptive eligibility
Alabama	100	Y	Y	Y
Alaska	100	Y	Y	N
Arizona	100	Y	Y	N
Arkansas	100	Y	Y	Y
California	185	N	N	N
Colorado	75	N	N	[2]Y
Connecticut	185	Y	Y	N
Delaware	100	Y	Y	N
District of Columbia	100	Y	Y	N
Florida	150	Y	Y	Y
Georgia	100	Y	Y	N
Hawaii	[2]185	Y	Y	Y
Idaho	75	Y	Y	Y
Illinois	100	N	Y	Y
Indiana	100	Y	Y	Y
Iowa	185	N	Y	Y
Kansas	150	Y	N	N
Kentucky	125	N	Y	N
Louisiana	100	Y	Y	Y
Maine	185	Y	N	Y
Maryland	185	Y	Y	Y
Massachusetts	185	Y	Y	Y
Michigan	185	Y	Y	N
Minnesota	185	Y	Y	N
Mississippi	185	Y	Y	N
Missouri	100	N	Y	N
Montana	100	Y	N	N
Nebraska	100	Y	Y	Y
Nevada	75	Y	N	N
New Hampshire	75	Y	N	N
New Jersey	100	Y	Y	Y
New Mexico	100	Y	Y	Y
New York	185	Y	Y	Y
North Carolina	100	Y	Y	Y
North Dakota	75	N	N	N
Ohio	100	Y	Y	N
Oklahoma	100	Y	Y	N
Oregon	85	Y	Y	N
Pennsylvania	100	Y	N	Y
Rhode Island	185	Y	Y	N
South Carolina	185	Y	Y	N
South Dakota	100	Y	Y	N
Tennessee	100	Y	Y	Y
Texas	130	N	Y	Y
Utah	100	Y	Y	Y
Vermont	185	Y	Y	N
Virginia	100	Y	Y	N
Washington	185	Y	Y	N
West Virginia	150	Y	Y	N
Wisconsin	[3]120	N	N	Y
Wyoming	100	Y	Y	N

[1] Coverage of children and pregnant women under 75 percent of the poverty level was made mandatory in 1989. Effective April 1, 1990, coverage of pregnant women and of children under age 6 under 133 percent of poverty became mandatory.

[2] Future implementation date.

[3] State-funded program covers infants and pregnant women at this level.

NOTES: Y is yes; N is no. Forty-two States no longer required an assets test for Medicaid eligibility for pregnant women, 41 States implemented continuous eligibility provisions, and 23 States implemented presumptive eligibility provisions. Under continuous eligibility, pregnant women who are eligible for Medicaid sometime during pregnancy can be granted continuous coverage for up to 60 days postpartum, regardless of changes in eligibility status. Presumptive eligibility allows specific primary care providers to authorize short-term Medicaid eligibility status for pregnant women.

SOURCE: National Governors' Association: *A Catalogue of State Medicaid Program Changes.* Washington. National Governors' Association, 1989.

References

Code of Federal Regulations: Public Health. Title 42. Office of the Federal Register, National Archives and Records Administration. Washington. U.S. Government Printing Office, October 1, 1986.

Congressional Research Service: Medicaid Source Book: Background Data and Analysis. 100th Congress, 2nd Session, Committee Print 100-AA. Washington. U.S. Government Printing Office, Nov. 1988.

Health Care Financing Administration: *Analysis of State Medicaid Program Characteristics, 1986.* HCFA Pub. No. 03249. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Aug. 1987a.

Health Care Financing Administration: *End-Stage Renal Disease, 1985.* HCFA Pub. No. 03274. Bureau of Data Management and Strategy and Office of Research and Demonstrations. Washington. U.S. Government Printing Office, Sept. 1987b.

Health Care Financing Administration: National health expenditures, 1986-2000. *Health Care Financing Review.* Vol. 8, No. 4. HCFA Pub. No. 03239. Office of Research and Demonstrations. Washington. U.S. Government Printing Office, Aug. 1987c.

Health Care Financing Administration, Bureau of Quality Control: Data from the Third Party Liability Branch, 1988d.

Health Care Financing Administration, Office of Prepaid Health Care: Data from the Division of Contract Administration, 1988e.

Health Care Financing Administration: *End Stage Renal Disease, 1988.*Research Report. HCFA Pub. No. 03299. Bureau of Data Management and Strategy and Office of Research and Demonstrations. Washington. U.S. Government Printing Office. Sept. 1990.

Intergovernmental Health Policy Project: *State Systems for Hospital Payment.* Contract No. T-56951792. Prepared for the Prospective Payment Assessment Commission. Washington, Apr. 1989.

Klarman, H.E., Rice, D.P., Cooper, B.S., and Stettler, H.L.: *Sources of Increase in Selected Medical Care Expenditures, 1929-1969.* Staff Paper No. 4. Office of Research and Statistics, Social Security Administration. Baltimore, Apr. 1970.

Latta, V.: Use and cost of short-stay hospital inpatient services under Medicare: Calendar year 1985. *Research Brief.* No. 88-1. Office of Research and Demonstrations, Health Care Financing Administration, Baltimore, MD., 1988.

National Center for Health Statistics: *Health, United States, 1988.* DHHS Pub. No. (PHS)89-1232. Public Health Service. Washington. U.S. Government Printing Office, Mar. 1989.

National Governors' Association: *A Catalogue of State Medicaid Program Changes.* Washington. National Governors' Association, 1989.

Plotnick, R., and Danziger, S.: Poverty rates by State in the mid-1980s: An update. *Focus* 11(3):12-14, 1988

Appendix A

Medicare carriers and intermediaries

Blue Cross Association

Blue Cross and Blue Shield Association
676 North St. Clair Street
Chicago, Illinois 60611

Blue Cross plans

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Alaska—See Blue Cross of Washington and Alaska

Blue Cross and Blue Shield of Arizona, Inc.
2410 W. Royal Palm Drive
Phoenix, Arizona 85021
Mailing address:
P.O. Box 37700
Phoenix, Arizona 85069

Arkansas Blue Cross and Blue Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

Blue Cross of California
21555 Oxnard Street
Woodland Hills, California 91367
Mailing address:
P.O. Box 70000
Van Nuys, California 91570

Colorado—See New Mexico Blue Cross and Blue Shield, Inc.

Blue Cross and Blue Shield of Connecticut, Inc.
370 Bassett Road
North Haven, Connecticut 06473

Blue Cross and Blue Shield of Delaware, Inc.
One Brandywine Gateway
P.O. Box 1991
Wilmington, Delaware 19899

District of Columbia—See Blue Cross and Blue Shield of Maryland

Blue Cross and Blue Shield of Florida, Inc.
532 Riverside Avenue
P.O. Box 1798
Jacksonville, Florida 32231

Blue Cross and Blue Shield of Georgia, Inc.
2357 Warm Springs Road
P.O. Box 7368
Columbus, Georgia 31908

Hawaii—See Hawaii Medical Service Association

Idaho—See Blue Cross and Blue Shield of Oregon

Health Care Service Corp.
233 North Michigan Avenue
Chicago, Illinois 60601

Associated Insurance Companies, Inc.
(d.b.a. Blue Cross and Blue Shield of Indiana)
120 West Market Street
Indianapolis, Indiana 46204-2805

IASD Health Services Corp.
636 Grand Avenue, Station 28
Des Moines, Iowa 50309

Blue Cross and Blue Shield of Kansas, Inc.
1133 Topeka Avenue
P.O. Box 239
Topeka, Kansas 66601

Blue Cross and Blue Shield of Kentucky, Inc.
9901 Linn Station Road
Louisville, Kentucky 40223

Louisiana Health Service and Indemnity Company
(d.b.a. Blue Cross of Louisiana)
10225 Florida Boulevard
Baton Rouge, Louisiana 70815-1791
Mailing address:
P.O. Box 95021
Baton Rouge, Louisiana 70895-9021

Associated Hospital Service of Maine
(d.b.a. Maine Blue Cross and Blue Shield)
110 Free Street
Portland, Maine 04101

Blue Cross and Blue Shield of Maryland, Inc.
P.O. Box 4368
1946 Greenspring Drive
Timonium Industrial Park
Timonium, Maryland 21093

Blue Cross and Blue Shield of Massachusetts, Inc.
100 Summer Street
Boston, Massachusetts 02106

Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield of Minnesota
3535 Blue Cross Road
P.O. Box 64357
St. Paul, Minnesota 55164

Blue Cross and Blue Shield of Mississippi, Inc.
3534 Lakeland Drive
P.O. Box 23035
Jackson, Mississippi 39225-3035

Blue Cross and Blue Shield of Missouri
4444 Forest Park
St. Louis, Missouri 63108

Blue Cross and Blue Shield of Montana
Great Falls Division:
3360 10th Avenue, South
P.O. Box 5004
Great Falls, Montana 59403
Helena Division:
404 Fuller Avenue
P.O. Box 4309
Helena, Montana 59601

Blue Cross and Blue Shield of Nebraska
7621 Mercy Road
Omaha, Nebraska 68124
Mailing address:
P.O. Box 3248
Main Post Office Station
Omaha, Nebraska 68180

Nevada—See Aetna Life and Casualty Company

NOTE: d.b.a. means "doing business as"

New Hampshire-Vermont
Health Service
Two Pillsbury Street
Concord, New Hampshire 03301

Blue Cross and Blue Shield of
New Jersey, Inc.
33 Washington Street
Newark, New Jersey 07102

New Mexico Blue Cross and
Blue Shield, Inc.
12800 Indian School Road, NE.
Albuquerque, New Mexico 87112
Mailing address:
P.O. Box 13597
Albuquerque, New Mexico 87192-3597

Empire Blue Cross and Blue Shield
622 Third Avenue
New York, New York 10017

Blue Cross and Blue Shield of
North Carolina
P.O. Box 2291
Durham, North Carolina 27702

Blue Cross and Blue Shield
of North Dakota
4510 13th Avenue, SW.
Fargo, North Dakota 58121

Community Mutual Insurance
Company
Medicare operations:
Randall Building, Holiday
Office Park
P.O. Box 145482
801 West Eight Street
Cincinnati, Ohio 45250-5482

Group Health Service of
Oklahoma, Inc.
1215 South Boulder Avenue
Tulsa, Oklahoma 74119

Blue Cross and Blue Shield of
Oregon
100 SW. Market Street
Portland, Oregon 97201
Mailing address:
P.O. Box 8110
Portland, Oregon 97207-8110

Independence Blue Cross
1901 Market Street
Philadelphia, Pennsylvania 19103

Blue Cross of
Western Pennsylvania
Fifth Avenue Place
Pittsburgh, Pennsylvania 15222

Blue Cross and Blue Shield of
Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Blue Cross and Blue Shield of
South Carolina
Fontaine Business Center
300 Arbor Lake Drive, Suite 1300
Columbia, South Carolina 29223

South Dakota—See IASD Health
Services Corp.

Blue Cross and Blue Shield of
Tennessee
801 Pine Street
Chattanooga, Tennessee 37402

Blue Cross and Blue Shield of
Texas, Inc.
901 South Central Expressway
Richardson, Texas 75080
Mailing address:
P.O. Box 660156
Dallas, Texas 75266-0156

Blue Cross and Blue Shield of Utah
2455 Parley's Way
P.O. Box 30270
Salt Lake City, Utah 84130

Vermont—See New Hampshire-
Vermont Health Service

Blue Cross and Blue Shield of
Virginia
602 South Jefferson Street
P.O. Box 12201
Roanoke, Virginia 24023-2201

Blue Cross of Washington and Alaska
7001-220th SW.
Mountlake Terrace, Washington 98043
Mailing address:
P.O. Box 2847
Seattle, Washington 98111-2847

Blue Cross and Blue Shield of
West Virginia, Inc.
P.O. Box 231
Charleston, West Virginia 25321

Blue Cross and Blue Shield United
of Wisconsin
1515 N. River Center Drive
Milwaukee, Wisconsin 53212
Mailing address:
P.O. Box 2025
Milwaukee, Wisconsin 53212-2025

Blue Cross and Blue Shield of
Wyoming
4000 House Avenue
P.O. Box 2266
Cheyenne, Wyoming 82001

Blue Shield plans

Blue Cross and Blue Shield of
Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Alaska—See Aetna Life
and Casualty Company

Arizona—See Aetna Life
and Casualty Company

Arkansas Blue Cross and
Blue Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

California Physicians' Service
(d.b.a. Blue Shield of California)
1 Beach Street
San Francisco, California 94133
Mailing address:
P.O. Box 7013
San Francisco, California 94120

Rocky Mountain Hospital and
Medical Service
(d.b.a. Blue Cross and Blue Shield
of Colorado)
700 Broadway
Denver, Colorado 80273

Connecticut—See The
Travelers Insurance Company

Delaware—See Pennsylvania
Blue Shield

District of Columbia—See
Pennsylvania Blue Shield

Blue Cross and Blue Shield of
Florida, Inc.
532 Riverside Avenue
P.O. Box 1798
Jacksonville, Florida 32231

Georgia—See Aetna Life
and Casualty Company

Hawaii—See Aetna Life
and Casualty Company

Idaho—See EQUICOR, Inc.

NOTE: d.b.a. means "doing business as"

Health Care Service Corporation
233 North Michigan Avenue
Chicago, Illinois 60601

Associated Insurance Companies, Inc.
(d.b.a. Blue Cross and Blue Shield of Indiana)
120 West Market Street
Indianapolis, Indiana 46204-0452

IASD Health Services Corp.
636 Grand Avenue, Station 28
Des Moines, Iowa 50309

Blue Cross and Blue Shield of Kansas, Inc.
1133 Topeka Avenue
P.O. Box 239
Topeka, Kansas 66601

Blue Cross and Blue Shield of Kentucky, Inc.
100 East Vine Street
6th Floor
Lexington, Kentucky 40507

Louisiana—See Arkansas Blue Cross and Blue Shield, Inc.

Maine—See Blue Cross and Blue Shield of Massachusetts, Inc.

Blue Cross and Blue Shield of Maryland, Inc.
P.O. Box 4368
1946 Greenspring Drive
Timonium Industrial Park
Timonium, Maryland 21093

Blue Cross and Blue Shield of Massachusetts, Inc.
100 Summer Street
Boston, Massachusetts 02106

Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield of Minnesota
Waterview Office Tower
1200 Yankee Doodle Road
Eagan, Minnesota 55122
Mailing address:
P.O. Box 64357
St. Paul, Minnesota 55164

Mississippi—See The Travelers Insurance Company

NOTE: d.b.a. means "doing business as."

Blue Cross and Blue Shield of Kansas City
2301 Main
P.O. Box 419840
Kansas City, Missouri 64141

Blue Cross and Blue Shield of Montana, Inc.
P.O. Box 4309
404 Fuller Avenue
Helena, Montana 59601

Nebraska—See Blue Cross and Blue Shield of Kansas, Inc.

Nevada—See Aetna Life and Casualty Company

New Hampshire—See Blue Cross and Blue Shield of Massachusetts

New Jersey—See Pennsylvania Blue Shield

New Mexico—See Aetna Life and Casualty Company

Blue Shield of Western New York, Inc.
275 Oak Street
P.O. Box 356
Buffalo, New York 14240-0356

Empire Blue Cross and Blue Shield
622 Third Avenue
New York, New York 10017

Blue Cross and Blue Shield of North Dakota
4510 13th Avenue, SW.
Fargo, North Dakota 58121

Ohio—See Nationwide Mutual Insurance Company

Oklahoma—See Aetna Life and Casualty Company

Oregon—See Aetna Life and Casualty Company

Pennsylvania Blue Shield
P.O. Box 89065
Camp Hill, Pennsylvania 17089-0065

Seguros de Servicio de Salud de Puerto Rico, Inc.
G.P.O. Box 3628
San Juan, Puerto Rico 00936-3628

Blue Cross and Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Blue Cross and Blue Shield of South Carolina, Medicare
Fontaine Business Center
300 Arbor Lake Drive
Suite 1300
Columbia, South Carolina 29223

South Dakota—See Blue Shield of North Dakota

Tennessee—See EQUICOR, Inc.

Blue Cross and Blue Shield of Texas, Inc.
901 South Central Expressway
Richardson, Texas 75080

Blue Cross and Blue Shield of Utah
2455 Parley's Way
P.O. Box 30270, Medicare B
Salt Lake City, Utah 84130

Vermont—See Blue Cross and Blue Shield of Massachusetts

Virginia—See The Travelers Insurance Company

Washington Physicians' Service
4th & Battery Building, 6th Floor
2401 4th Avenue
Seattle, Washington 98121

West Virginia—See Nationwide Mutual Insurance Company

Wisconsin—See Wisconsin Physicians' Service Insurance Corporation

Wyoming—See EQUICOR, Inc.

Commercial, independent, State, and other

Aetna Life and Casualty Company
151 Farmington Avenue
Hartford, Connecticut 06156

Blue Cross and Blue Shield of Missouri
4444 Forest Park
St. Louis, Missouri 63108

Cooperativa de Seguros de Vida de Puerto Rico
G.P.O. Box 3428
San Juan, Puerto Rico 00936-3428

EQUICOR, Inc.
195 Broadway, 11th Floor
New York, New York 10007

General American Life Insurance Company
13045 Tesson Ferry Road
St. Louis County, Missouri 63128
Mailing address:
P.O. Box 505
St. Louis, Missouri 63166

Group Health Incorporated
88 West End Avenue
New York, New York 10023

Hawaii Medical Service Association
Medicare Administration
818 Keeaumoku
P.O. Box 860
Honolulu, Hawaii 96808

Mutual of Omaha Insurance Company
P.O. Box 1602
Omaha, Nebraska 68101

Nationwide Mutual Insurance Company
Three Nationwide Plaza
P.O. Box 16788 or P.O. Box 16781
Columbus, Ohio 43216

Transamerica Occidental Life Insurance Company
1149 S. Broadway, 3rd Floor
Los Angeles, California 90015
Mailing address:
P.O. Box 54905
Los Angeles, California 90054-0905

The Travelers Insurance Company
2 Riverview Square East
Hartford, Connecticut 06118

Wisconsin Physicians' Service Insurance Corporation
P.O. Box 1787
Madison, Wisconsin 53701

Railroad Retirement Board
Attention: BRCMPS
844 Rush Street
Chicago, Illinois 60611

Appendix B
Medicaid agencies and fiscal agents

Single State agencies and State medical assistance units

Alabama (Region IV):
Single State agency and medical assistance unit:
Alabama Medicaid Agency
2500 Fairlane Drive
Montgomery, Alabama 36130
205 277-2710

Alaska (Region X):
Single State agency:
Alaska Department of Health and Social Services
P.O. Box H-01
Juneau, Alaska 99811-0601
907 465-3355

Medical assistance unit:
Division of Medical Assistance
Alaska Department of Health and Social Services
P.O. Box H-07
Juneau, Alaska 99811-0601

Arizona (Region IX):
Single State agency and medical assistance unit:
Arizona Health Care Cost Containment System Administration
801 East Jefferson Street
Phoenix, Arizona 85034
602 234-3655

Arkansas (Region VI):
Single State agency:
Arkansas Department of Human Services
Seventh and Main Streets
P.O. Box 1437
Little Rock, Arkansas 72203
501 371-1001

Medical assistance unit:
Office of Medical Services
Arkansas Division of Economic and Medical Services
P.O. Box 1437
Little Rock, Arkansas 72203
501 371-1806

California (Region IX):
Single State agency:
California State Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814
916 445-1248

Medical assistance unit:
California State Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814
916 322-5824

Colorado (Region VII):
Single State agency:
Colorado Department of Social Services
P.O. Box 181000
Denver, Colorado 80218-0899
303 294-5800

Medical assistance unit:
Colorado Department of Social Services
P.O. Box 181000
Denver, Colorado 80218-0899
303 294-5901

Connecticut (Region I):
Single State agency:
Connecticut Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203 566-2008

Medical assistance unit:
Medical Care Administration
Connecticut Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203 566-2934

Delaware (Region III):
Single State agency:
Delaware Department of Health and Social Services
Administration Building
Delaware State Hospital
P.O. Box 906
New Castle, Delaware 19720
302 421-6705

Medical assistance unit:
Medical Assistance Services
Delaware Department of Health and Social Services
Delaware State Hospital
P.O. Box 906
New Castle, Delaware 19720
302 421-6139

District of Columbia (Region III):
Single State agency:
Department of Human Services
801 North Capital Street
Room 700
Washington, D.C. 20002
202 727-0450

Medical assistance unit:
Office of Health Care Financing/Office of the Controller
D.C. Department of Human Services
1331 H Street, NW.
Room 500
Washington, D.C. 20005
202 727-0735

Florida (Region IV):
Single State agency:
Florida Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, Florida 32301
904 488-7721

Medical assistance unit:
Florida Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Building 6, Room 233
Tallahassee, Florida 32301
904 488-3560

Georgia (Region IV):
Single State agency and medical assistance unit:
Georgia Department of Medical Assistance
2 Martin Luther King Drive
1220 West Tower
Atlanta, Georgia 30334
404 656-4479

Guam (Region IX):
Single State agency and medical assistance unit:
Department of Public Health and Social Services
P.O. Box 2816
Agana, Guam 96910
671 734-2083

Hawaii (Region IX):
Single State agency:
Hawaii Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808 548-6260

Medical assistance unit:
Health Care Administration Division
Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808 548-3855

Idaho (Region X):
Single State agency:
Idaho Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208 334-5500

Medical assistance unit:
Bureau of Medical Assistance
Idaho Department of Health and Welfare
450 W. State Street
Statehouse
Boise, Idaho 83720
208 334-5794

Illinois (Region V):
Single State agency:
Illinois Department of Public Aid
Jesse B. Harris Building II
2nd Floor
100 South Grand Avenue, East
Springfield, Illinois 62762
217 782-6716

Medical assistance unit:
Illinois Department of Public Aid
628 East Adams Street
3rd Floor
Springfield, Illinois 62761
217 782-2570

Indiana (Region V):
Single State agency:
Indiana Department of Public Welfare
State Office Building
100 North Senate Avenue
Room 701
Indianapolis, Indiana 46204
317 232-4705

Medical assistance unit:
Indiana Department of Public Welfare
100 North Senate Avenue
State Office Building, Room 702
Indianapolis, Indiana 46204
317 232-4324

Iowa (Region VII):
Single State agency:
Iowa Department of Human Services
Hoover State Office Building
5th Floor
Des Moines, Iowa 50319
515 281-5452

Medical assistance unit:
Bureau of Medical Services
Iowa Department of Human Services
Hoover State Office Building
5th Floor
Des Moines, Iowa 50319
515 281-8794

Kansas (Region VII):
Single State agency:
Kansas Department of Social and Rehabilitation Services
State Office Building, 6th Floor
Room 628-S
Topeka, Kansas 66612
913 296-3271

Medical assistance unit:
Kansas Department of Social and Rehabilitation Services
Room 628-S
State Office Building, 6th Floor
Topeka, Kansas 66612
913 296-3981

Kentucky (Region IV):
Single State agency and medical assistance unit:
Kentucky Department for Medicaid Services
CHR Building
275 East Main Street
Frankfort, Kentucky 40621
502 564-4321

Louisiana (Region VI):
Single State agency:
Louisiana Department of Health and Human Resources
P.O. Box 3776
Baton Rouge, Louisiana 70821
504 342-6711

Medical assistance unit:
Medical Assistance Programs
Louisiana Department of Health and Human Resources
P.O. Box 44065
Baton Rouge, Louisiana 70804
504 342-3956

Maine (Region I):
Single State agency:
Maine Department of Human Services
221 State Street
Statehouse, Station II
Augusta, Maine 04333
207 289-2736

Medical assistance unit:
Bureau of Medical Services
Whitten Road
Statehouse, Station II
Augusta, Maine 04333
207 289-2674

Maryland (Region III):
Single State agency:
Maryland Department of Health and Mental Hygiene
Herbert R. O'Connor Building
201 West Preston Street
Baltimore, Maryland 21201
301 225-6500

Medical assistance unit:
Maryland Department of Health and Mental Hygiene
Herbert R. O'Connor Building
201 West Preston Street
Room 524
Baltimore, Maryland 21201
301 225-6535

Massachusetts (Region I):
Single State agency:
Massachusetts Department of Public Welfare
180 Tremont Street
Boston, Massachusetts 02111
617 574-0200

Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617 727-5550

Medical assistance unit:
Massachusetts Department of Public Welfare
180 Tremont Street
Boston, Massachusetts 02111
617 574-0205

Medical assistance:
Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617 727-5550

Michigan (Region V):
Single State agency:
Michigan Department of Social Services
300 South Capitol Avenue
P.O. Box 30037
Lansing, Michigan 48909
517 373-2000

Medical assistance unit:
Michigan Department of Social Services
921 West Holmes
P.O. Box 30037
Lansing, Michigan 48909
517 334-7262

Minnesota (Region V):
Single State agency:
Minnesota Department of Human Services
Centennial Office Building
4th Floor
658 Cedar Street
Saint Paul, Minnesota 55155
612 296-2701

Medical assistance unit:
Bureau of Income Maintenance
Minnesota Department of Public Welfare
Space Center Building, 1st Floor
444 Lafayette Road
Saint Paul, Minnesota 55101
612 296-2766

Mississippi (Region IV):
Single State agency and medical assistance unit:
Division of Medicaid
Office of the Governor
4785 1-55 North
P.O. Box 16786
Jackson, Mississippi 39236-0786
601 981-4507

Missouri (Region VII):
Single State agency:
Missouri Department of Social Services
Broadway State Office Building
Jefferson City, Missouri 65102
314 751-4815

Medical assistance unit:
Division of Medical Services
Missouri Department of Social Services
308 East High Street
P.O. Box 6500
Jefferson City, Missouri 65103
314 751-6922

Montana (Region VII):
Single State agency:
Montana Department of Social and Rehabilitative Services
P.O. Box 4210
Helena, Montana 59604
406 444-5622

Medical assistance unit:
Economic Assistance Division
Montana Department of Social and Rehabilitative Services
P.O. Box 4210
Helena, Montana 59604
406 444-4540

Nebraska (Region VII):
Single State agency:
Nebraska Department of Social Services
301 Centennial Mall South
5th Floor
Lincoln, Nebraska 68509
402 471-3121

Medical assistance unit:
Nebraska Department of Social Services
301 Centennial Mall South
5th Floor
Lincoln, Nebraska 68509
402 471-9330

Nevada (Region IX):
Single State agency:
Nevada Department of Human Resources
Kinkead Building—Capitol Complex
505 East King Street
Carson City, Nevada 89710
702 885-4730

Medical assistance unit:
Welfare Division
Department of Human Resources
Capitol Complex
2527 North Carson Street
Carson City, Nevada 89710
702 885-4698

New Hampshire (Region I):
Single State agency:
New Hampshire Department of Health and Human Services
6 Hazen Drive
Concord, New Hampshire 03301-6521
603 271-4331

Medical assistance unit:
Office of Medical Services
New Hampshire Division of Health and Human Services
6 Hazen Drive
Concord, New Hampshire 03301-6521
603 271-4353

New Jersey (Region II):
Single State agency:
New Jersey Department of Human Services
Capitol Place One
222 South Warren Street
Trenton, New Jersey 08625
609 292-3717

Medical assistance unit:
Division of Medical Assistance and Health Services
New Jersey Department of Human Services
Building No. 7
Quakerbridge Plaza, CN 712
Trenton, New Jersey 08625
609 588-2600

New Mexico (Region VI):
Single State agency:
New Mexico Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503-2348
505 827-4072

Medical assistance unit:
Medical Assistance Division
New Mexico Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503-2348
505 827-4315

New York (Region II):
Single State agency:
New York State Department of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243
518 474-9475

Medical assistance unit:
Division of Medical Assistance
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243
518 474-9132

North Carolina (Region IV):
Single State agency:
North Carolina Department of Human Resources
325 North Salisbury Street
Raleigh, North Carolina 27611
919 733-4534

Medical assistance unit:
Division of Medical Assistance
North Carolina Department of Human Resources
1985 Umstead Drive
Raleigh, North Carolina 27603
919 733-2060

North Dakota (Region VIII):
Single State agency:
North Dakota Department of Human Services
State Capitol Building
Bismarck, North Dakota 58505
701 224-2310

Medical assistance unit:
North Dakota Department of Human Services
State Capitol Building
Bismarck, North Dakota 58505
701 224-2321

Ohio (Region V):
Single State agency:
Ohio Department of Human Services
30 East Broad Street, 32nd Floor
Columbus, Ohio 43266-0423
614 466-6282

Medical assistance unit:
Ohio Department of Human Services
30 East Broad Street, 31st Floor
Columbus, Ohio 43266-0423
614 466-3196

Oklahoma (Region VI):
Single State agency:
Oklahoma Department of Human Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405 521-3646

Medical assistance unit:
Medical Services Division
Oklahoma Department of Human Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405 557-2540

Oregon (Region X):
Single State agency:
Oregon Department of Human Resources
318 Public Service Building
Salem, Oregon 97310
503 378-3034

Medical assistance unit:
Adult and Family Services Division
Oregon Department of Human Resources
203 Public Service Building
Salem, Oregon 97310
503 378-2263

Pennsylvania (Region III):
Single State agency:
Pennsylvania State Department of Public Welfare
Health and Welfare Building
Room 333
Harrisburg, Pennsylvania 17120
717 787-2600

Medical assistance unit:
Pennsylvania State Department of Public Welfare
Health and Welfare Building
Room 515
Harrisburg, Pennsylvania 17120
717 787-1870

Puerto Rico (Region II):
Single State agency:
Puerto Rico Department of Health
P.O. Box 70184
San Juan, Puerto Rico 00936
809 751-8259

Medical assistance unit:
Health Economy Office
Department of Health
P.O. Box 9342
San Juan, Puerto Rico 00936
809 765-9941

Rhode Island (Region I):
Single State agency:
Rhode Island Department of Human Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401 464-2121

Medical assistance unit:
Rhode Island Department of Human Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401 464-3575

South Carolina (Region IV):
Single State agency:
South Carolina State Health and Human Services Finance Commission
P.O. Box 8206
Columbus, South Carolina 29202-8206
803 253-6100

Medical assistance unit:
Bureau of Health Services
South Carolina State Health and Human Services Finance Commission
P.O. Box 8206
Columbus, South Carolina 29202-8206
803 253-6119

South Dakota (Region VIII):
Single State agency:
South Dakota Department of Social Services
Kneip Building
700 North Illinois Street
Pierre, South Dakota 57501
605 773-3165

Medical assistance unit:
Office of Medical Services
South Dakota Department of Social Services
Kneip Building
700 North Illinois Street
Pierre, South Dakota 57501
605 773-3495

Tennessee (Region IV):
Single State agency:
Tennessee Department of Health and Environment
344 Cordell Hull Building
Nashville, Tennessee 37219
615 741-0213

Medical assistance unit:
Bureau of Medicaid
Tennessee Department of Health and Environment
729 Church Street
Nashville, Tennessee 37219
615 741-0213

Texas (Region VI):
Single State agency:
Texas Department of Human Services
P.O. Box 2960
Austin, Texas 78769
512 450-3030

Medical assistance unit:
Texas Department of Human Services
P.O. Box 2960
Austin, Texas 78769
512 450-3050

Utah (Region VIII):
Single State agency:
Utah Department of Health
P.O. Box 16700
Salt Lake City, Utah 84116-0700
801 538-6111

Medical assistance unit:
Division of Health Care Financing
Utah Department of Health
P.O. Box 16580
Salt Lake City, Utah 84116-0580
801 538-6151

Vermont (Region I):
Single State agency:
Vermont Department of Social Welfare
Agency of Human Services
103 South Main Street
Waterbury, Vermont 05676
802 241-2220

Medical assistance unit:
Division of Medical Services
Vermont Department of Social Welfare
Agency of Human Services
103 South Main Street
Waterbury, Vermont 05676
802 241-2880

Virgin Islands (Region II):
Single State agency:
Virgin Islands Department of Health
P.O. Box 7309
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809 774-0117

Medical assistance unit:
Bureau of Health Insurance and Medical Assistance
Virgin Islands Department of Health
P.O. Box 7309
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809 773-2150

Virginia (Region III):
Single State agency and medical assistance unit:
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
804 786-7933

Washington (Region X):
Single State agency and medical assistance unit:
Division of Medical Assistance
Washington Department of Social and Health Services
Mail Stop HB-41
Olympia, Washington 98504
206 753-1777

West Virginia (Region III):
Single State agency and medical assistance unit:
West Virginia Department of Human Services
1900 Washington Street, East
Charleston, West Virginia 25305
304 348-8990

Wisconsin (Region V):
Single State agency:
Wisconsin Department of Health and Social Services
1 West Wilson Street, Room 650
P.O. Box 7850
Madison, Wisconsin 53702
608 266-3681

Medical assistance unit:
Bureau of Health Care Financing
Wisconsin Department of Health and Social Services
1 West Wilson Street, Room 250
P.O. Box 309
Madison, Wisconsin 53701
608 266-2522

Wyoming (Region VIII):
Single State agency:
Wyoming Department of Health and Social Services
Hathaway Building
Cheyenne, Wyoming 82002
307 777-7121

Medical assistance unit:
Medical Assistance Services
Division of Health and Social Services
Hathaway Building, Room 450
Cheyenne, Wyoming 82002
307 777-7531

Medicaid fiscal agents and health insuring agencies

Jurisdiction	Fiscal agent(s) or health insuring agency	Type of claims handled
Alabama	Alacaid	Inpatient hospital, outpatient hospital, rural health clinic, laboratory and X-ray, skilled nursing facility, EPSDT, family planning, physician, optometrist, home health, clinic, physical therapy, prescribed drugs, prosthetic devices, eyeglasses, intermediate care facility, nurse midwife, transportation, ambulatory surgical center.
Alaska	Computer Sciences Corporation	Hospital inpatient, hospital outpatient, physician, pharmacy, dental, nursing facility, EPSDT, other medical providers.
Arizona	No fiscal agent	
Arkansas	Electronic Data Systems Federal	Inpatient hospital, outpatient hospital, rural health clinic, laboratory and X-ray, skilled nursing facility, EPSDT, family planning, physician, optometrist, chiropractor, clinic, dental, prescribed drugs, dentures, prosthetic devices, eyeglasses, rehabilitative, intermediate care facility, emergency hospital, personal care.
California	Computer Sciences Corporation	Inpatient, outpatient, long-term care, drugs, medical/professional, vision care. Crossover claims included.
Colorado	Computer Sciences Corporation	Inpatient, outpatient, physician, other practitioners, HCBS, transportation, supplies, laboratory and X-ray, dental, pharmacy, long-term care, EPSDT.
Connecticut	Electronic Data Systems Federal	Inpatient, outpatient, professional provider, dental, skilled nursing facility, intermediate care facility for the mentally retarded, long-term care, drug and pharmacy, optical, mental health. Crossover claims included.
Delaware	The Computer Company	Dental, drugs, inpatient, outpatient, EPSDT, physician, long-term care, intermediate care, home health, X-ray and laboratory, special services.
District of Columbia	The Computer Company	Physician, dental, pharmacy, home health, laboratory and X-ray, inpatient hospital, outpatient hospital, long-term care, transportation, health maintenance organization, vision care, durable medical equipment, EPSDT. Crossover claims included.
Florida	Electronic Data Systems	Inpatient hospital, outpatient hospital, physician, podiatry, ambulatory surgical, advanced registered nurse practitioner, birthing centers, community mental health, State mental health hospital, dental, EPSDT, family planning, health maintenance organization, hearing, waiver services, hospice care, home health, intermediate care facility for the mentally retarded, laboratory and X-ray, prescribed drugs, rural health clinic, vision, transportation, skilled and intermediate nursing home.

NOTE: EPSDT means early and periodic screening, diagnosis, and treatment.

Jurisdiction	Fiscal agent(s) or health insuring agency	Type of claims handled
Georgia	Electronic Data Systems	Hospital inpatient and outpatient, nursing homes (State-owned skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded), pharmacy, ambulance, home health, durable medical equipment, orthotics and prosthetics, optical, mental health, EPSDT, family planning, nonemergency transportation, physician, osteopath, dentist, optometrist, podiatrist, psychologist, chiropractor, rural health therapy, nurse midwifery, out-of-State services.
Hawaii	Hawaii Medical Services Association	Professional medical, inpatient, outpatient, dental, drugs, durable medical equipment, vision, air transportation, EPSDT, long-term care. Crossover claims included.
Idaho	Electronic Data Systems Corporation	Hospital outpatient, inpatient, physician, dental, EPSDT, nursing home.
Illinois	No fiscal agent	
Indiana	Indiana Blue Cross/Blue Shield	Long-term care, inpatient hospital, outpatient hospital, dental, pharmacy, EPSDT, medical. Crossover claims included.
Iowa	Systems Development Corporation Integrated, Inc.	Inpatient hospital, outpatient hospital, physician, skilled nursing facility, laboratory and X-ray, home health, EPSDT, family planning clinics, drug, dental, chiropractor, podiatry, optometry, opticians, audiology, physical therapy, intermediate care facility, ambulance, durable medical equipment, psychologist, clinic.
Kansas	Electronic Data Systems Federal	Inpatient hospital, outpatient hospital, hearing aid dealer, laboratory and X-ray, Indian Health Service, ambulance, intermediate care facility, intermediate care facility for the mentally retarded, skilled nursing facility, physician, osteopath, rural health clinic, chiropractor, psychologist, podiatrist, optometrist, optician, audiologist, rehabilitation center, dentist, clinic, family planning, home health, pharmacy.
Kentucky	Electronic Data Systems	Prescribed drugs, physician, dental, inpatient hospital, outpatient hospital, ambulatory surgical center, renal dialysis, home health, vision, audiology, community mental health center, nurse midwife, family planning, home health, independent laboratory, birthing center, AIS/MR, home and community-based and adult day care, nurse anesthetist, podiatry, hospice screening, EPSDT, transportation, ambulance, primary care, rural health, mental hospital, long-term care facility, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded.

NOTE: EPSDT means early and periodic screening, diagnosis, and treatment.

Jurisdiction	Fiscal agent(s) or health insuring agency	Type of claims handled
Louisiana	Systems Development Corporation	Inpatient hospital, outpatient hospital, rural health clinic, laboratory and X-ray, skilled nursing facility, EPSDT, family planning, physician, clinic, dental, physical therapy, occupational therapy, speech, hearing, and language disorder, prescribed drugs, dentures, prosthetic devices, eyeglasses, rehabilitative, intermediate care facility.
Maine	No fiscal agent	
Maryland	No fiscal agent	
Massachusetts	Systems Development Corporation	Inpatient, outpatient, professional provider, transportation, dental, skilled nursing facility, intermediate care facility for the mentally retarded, drug and pharmacy, home health agency, optical, mental health, long-term care.
Michigan	No fiscal agent	
Minnesota	No fiscal agent	
Mississippi	Blue Cross/Blue Shield	Physician, inpatient, outpatient, pharmacy, long-term care claims, EPSDT, dental regular, EPSDT dental, eyeglasses, hearing aids, ambulance, transportation, ESC—pharmacy, inpatient, outpatient, transportation, home health. Crossover claims included.
Missouri	General American Consultec	Ambulance, audiologist, dentist, durable medical equipment, inpatient hospital, outpatient, home health, clinic, independent laboratory and X-ray, mental hospital, nursing home, optician, optometrist, pharmacy, physician, podiatrist, rehabilitation center, rural health clinic.
Montana	General American Consultec	Physician, inpatient, outpatient, nursing, dental, pharmacy.
Nebraska	No fiscal agent	
Nevada	Blue Cross/Blue Shield of Nevada	Inpatient, outpatient, skilled nursing facility, intermediate care facility, professional/medical, dental, drugs, EPSDT. Crossover claims included.
New Hampshire	Electronic Data Systems Federal	Inpatient, outpatient, professional provider, dental, skilled nursing facility, EPSDT, drugs, pharmacy. Crossover claims included.
New Jersey	Blue Cross/Blue Shield of New Jersey, Inc.	Inpatient hospital, outpatient hospital, pharmacy, hospital-based home health. Crossover claims included.
	The Prudential Insurance Company of America	Inpatient hospital, outpatient hospital, freestanding and hospital-based home health agency, physician, dental, transportation, durable medical equipment, EPSDT, prosthetics and orthotics, vision care clinic. Crossover claims included.
	Inhouse—Division of Medical Assistance and Health Services	Inpatient, long-term care, skilled nursing facility, intermediate care facility, institutions for tuberculosis and mental disease.

NOTE: EPSDT means early and periodic screening, diagnosis, and treatment.

Jurisdiction	Fiscal agent(s) or health insuring agency	Type of claims handled
New Mexico	Electronic Data Systems Federal	Inpatient hospital, outpatient hospital, rural health clinic, laboratory and X-ray, skilled nursing facility, EPSDT, family planning, physician, podiatrist, optometrist, clinic, dental, physical therapy, prescribed drugs, dentures, prosthetic devices, eyeglasses, rehabilitative, intermediate care facility, emergency hospital.
New York	Computer Sciences Corporation	Pharmacy, inpatient, child care, diagnosis and treatment, dental, laboratory, clinical psychology, physician, outpatient, therapist, nursing, podiatry, long-term care.
North Carolina	Electronic Data Systems Federal	Inpatient hospital, outpatient hospital, laboratory and X-ray, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, home health, EPSDT, family planning, physician, rural health clinic, ambulance, prescribed drugs, chiropractor, podiatrist, optometrist, dental clinic, optical supplies, mental hospitals, personal care, health maintenance organizations, prepaid plans.
North Dakota	No fiscal agent	
Ohio	No fiscal agent	
Oklahoma	UNISYS	Inpatient hospital, outpatient hospital, rural health clinic, laboratory and X-ray, skilled nursing facility, EPSDT, family planning, physician, podiatrist, optometrist, dental, prescribed drugs, prosthetic devices, rehabilitative, intermediate care facility, personal care.
Oregon	No fiscal agent	
Pennsylvania	The Computer Company	Inpatient hospital, dental, podiatrist, optometrist, drug and alcohol abuse, home health, pharmacy, physician, ambulance, special services, laboratory and X-ray, outpatient clinic, long-term care, durable medical equipment, EPSDT.
Rhode Island	No fiscal agent	
South Carolina	No fiscal agent	
South Dakota	No fiscal agent	
Tennessee	The Computer Company	Inpatient and outpatient hospital, skilled nursing facility, home health, mental health, physician, laboratory and X-ray, vision, medical vendor, family planning, community health, ambulance, dental, pharmacy, EPSDT, intermediate care facility, home and community-based waiver services. Professional and professional crossover claims and special waiver project claims included.
Texas	National Heritage Insurance Company	All services except nursing home, prescribed drugs, adult day care, personal care in the recipient's home, transportation (other than ambulance).

NOTE: EPSDT means early and periodic screening, diagnosis, and treatment.

Jurisdiction	Fiscal agent(s) or health insuring agency	Type of claims handled
Utah	No fiscal agent	
Vermont	Electronic Data Systems Federal	Intermediate care facility, home health, optometrist, physician, podiatrist, ambulance, laboratory and X-ray, clinic, durable medical equipment, orthotics, prosthetics, rural health clinic, transportation.
Virginia	The Computer Company	Dental, drug, inpatient, outpatient, EPSDT, physician, skilled nursing care, intermediate care.
Washington	Consultec, Inc.	Hospital inpatient and outpatient, dental, physician, pharmacy, EPSDT, nursing home, other medical providers.
West Virginia	The Computer Company	Dental, drugs, hospital inpatient and outpatient, EPSDT, physician, other practitioners, clinic, laboratory and X-ray, transportation, durable medical equipment, medical supplies. Handicapped children programs claims included.
Wisconsin	Electronic Data Systems Federal	Drug, physician, dental, EPSDT, outpatient, medical vendor, inpatient, nursing home. Prior authorizations and crossover claims included.
Wyoming	No fiscal agent except for dental services	Automated: Dental for EPSDT.
	Dental (EPSDT) processed by Wyoming Dental Services	Manual: Inpatient, outpatient, physician, optometrist, home health, laboratory and X-ray, transportation.

NOTE: EPSDT means early and periodic screening, diagnosis, and treatment.

Appendix C

Where to call for information

Medicare

Assignment of Medicare claims
Bureau of Program Operations (301) 966-5994

Beneficiary assistance on claims and entitlement
Bureau of Program Operations (301) 966-6963

Beneficiary information
Division of Beneficiary Services
Office of Public Liaison (301) 966-3211

Benefit appeal procedures
Office of Financial Operations
Bureau of Program Operations (301) 966-7483

Benefit information
Bureau of Policy Development (301) 966-5601

Conditions of provider participation
Office of Survey and Certification
Health Standards and Quality Bureau (301) 966-6763

Contractor performance
Division of Operations Standards
Bureau of Program Operations (301) 966-7409

Deductibles: Explanation of beneficiary liability
Division of Beneficiary Services
Office of Public Liaison (301) 966-3211

Enrollment eligibility
Bureau of Policy Development (301) 966-4662
Eligibility and Administration Branch

Intermediary and carrier contracts
Office of Program Administration
Bureau of Program Operations (301) 966-7421

Medicare and Medicaid fraud, abuse, and waste
Health and Human Services (800) 638-3986 (MD toll free)
Office of the Inspector General (800) 368-5779 (nationwide toll free)

Medicare legislation
Division of Medicare
Office of Legislation and Policy (202) 245-0277

Medicare and Medicaid regulations: Regulations under development and status
Office of Regulations Management (301) 966-5244
Office of Executive Operations (202) 245-7890

Peer review organizations
Office of Peer Review
Health Standards and Quality Bureau (301) 966-6851

Physician services data
Medicare Program Studies Branch
Office of Research and Demonstrations (301) 966-7705

Prevailing charges directory
Office of Program Administration
Bureau of Program Operations (301) 966-6963

Problems: Beneficiaries
Division of Beneficiary Services
Office of Public Liaison (301) 966-3206

Problems: General
Office of Public Affairs (202) 245-6113

Procurements services - Medicare
Office of Financial Management and Procurement
Office of Budget and Administration (301) 966-5136

Program cost estimates
Office of Medicare Cost Estimates
Office of the Actuary (301) 966-6386

Provider certification
Office of Survey and Certification (301) 966-6763

Public information
Office of Public Affairs (Washington) (202) 245-6113

Publications: Health Care Financing Administration
Office of Public Affairs (Washington) (202) 245-6113

Publications: Office of Research and Demonstrations
Office of Research and Demonstrations
Publications and Information Resources Branch (301) 966-6584

Quality of care issues
Health Standards and Quality Bureau (301) 966-6860

Reasonable charges
Division of Medical Services Reimbursement
Bureau of Policy Development (301) 966-4497

Regional offices, Health Care Financing Administration
Boston (617) 835-1188
New York (212) 264-4488
Philadelphia (215) 596-1351
Atlanta (404) 242-2329
Chicago (312) 353-6432
Dallas (214) 767-6427
Kansas City (816) 426-5233
Denver (303) 844-2111
San Francisco (415) 995-6146
Seattle (206) 442-0425

Reimbursement methods
Division of Reimbursement and Economic Studies
Office of Research and Demonstrations (301) 966-6588

Reimbursement policy
Bureau of Policy Development (301) 966-4493

Research and demonstration studies
Office of Research and Demonstrations (301) 966-6507

Rural health clinics
Reimbursement:
Bureau of Policy Development (301) 966-4529
Survey and certification:
Health Standards and Quality Bureau (301) 966-6763

Service coverage
Office of Coverage Policy
Bureau of Policy Development (301) 966-4637

State and contractor standards
Office of Program Administration
Bureau of Program Operations (301) 966-7421

State buy-ins
Division of Entitlement Requirements
Bureau of Program Operations (301) 966-6464

Statistics: Assignment rates
Division of Reports and Analysis
Bureau of Program Operations (301) 966-5731

Statistics: Beneficiaries
Division of Program Studies
Office of Research and Demonstrations (301) 966-7705

Statistics: Contractor workloads and costs
Division of Reports and Analysis
Bureau of Program Operations (301) 966-5731

Statistics: General
Division of Information Analysis
Bureau of Data Management and Strategy (301) 597-3698

Statistics: Institutional and noninstitutional Medicare services
Division of Program Studies
Office of Research and Demonstrations (301) 966-7705

Statistics: Peer review organizations
Division of Program Operations
Health Standards and Quality Bureau (301) 966-6894

Medicaid

Administration and training cost data
Administrative Costs Branch
Division of Budget
Office of Budget and Administration (301) 966-2097

Beneficiary information
Office of Beneficiary Services (telephone inquiries) (Baltimore) (301) 966-3206
Office of Beneficiary Services (D.C.) (202) 245-7684

Early and periodic screening, diagnosis, and treatment data
Division of Financial Management
Bureau of Quality Control (301) 966-3257

Eligibility
Bureau of Eligibility, Reimbursement, and Policy Development (301) 966-5648

Eligibility error rates
Eligibility Assessment Branch
Division of Program Performance
Bureau of Quality Control (301) 966-3294

Expenditures
Total Program Expenditures
Division of Contractor Financial Management
Bureau of Program Operations (301) 966-7477

Federal financial participation
Division of Contractor Financial Management
Office of Financial Operations
Bureau of Program Operations (301) 966-7477

Freedom-of-choice waivers
Bureau of Policy Development (301) 966-4460

Home and community-based waivers
Office of Coverage Policy
Bureau of Policy Development (301) 966-5659

Medicaid fraud and abuse
Health and Human Services (800) 638-3986 (MD toll free)
Office of the Inspector General (800) 368-5779 (nationwide toll free)
Office of Investigations
State Fraud Branch (202) 472-3222

Medicaid institutional providers
Office of Statistics and Data Management
Bureau of Data Management and Strategy (301) 597-5063

Medicaid legislation
Division of Medicaid Legislation
Office of Legislation and Policy (202) 245-0036

Medicaid management information systems
Division of Payment Systems
Office of Medicaid Management
Bureau of Quality Control (301) 966-3292

Medicaid policy
Division of Medicaid and Long-Term Care Policy
Office of Policy Analysts
Office of Legislation and Policy (202) 245-0500

Medicaid vendor payments
Office of Medicaid Cost Estimates
Office of the Actuary (301) 966-7914

Medicare and Medicaid regulations: Regulations under development and status
Office of Regulations Management
Office of Executive Operations (301) 966-5239

Procurements—Medicaid
Division of Provider Procedures
Office of Program Operations Procedures
Bureau of Program Operations (301) 966-6127

Public information
Office of Public Affairs (Baltimore) (301) 966-5352
Office of Public Affairs (D.C.) (202) 245-6113

Publications: Office of Research and Demonstrations
Office of Research and Demonstrations
Publications and Information Resources Branch (301) 966-6584

Recipients
Office of Medicaid Cost Estimates
Office of the Actuary (301) 966-7914

Reference services
Congressional Affairs Branch
Office of Legislation and Policy (202) 245-8220

Regional offices, Health Care Financing Administration
Boston (617) 835-1188
New York (212) 264-4488
Philadelphia (215) 596-1351
Atlanta (404) 242-2329
Chicago (315) 353-6432
Dallas (214) 767-6427
Kansas City (816) 426-5233
Denver (303) 844-2111
San Francisco (415) 995-6146
Seattle (206) 442-0425

Research
Program Studies Branch (301) 966-7716
Office of Research and Demonstrations (301) 966-7718

State and local administration and training
Office of Financial Management and Procurement
Office of Budget and Administration (301) 966-2085

State assessment
Division of Performance Evaluation
Bureau of Quality Control (301) 966-3301

State certification cost data
Office of Survey and Certification
Health Standards and Quality Bureau (301) 966-6790

State data
Office of Medicaid Cost Estimates
Office of the Actuary (301) 966-7914

Statistics: General
Office of Medicaid Cost Estimates
Office of the Actuary (301) 966-7914

Supplemental Security Income
Social Security Administration
Division of Program Management and Analysis
Office of Supplemental Security Income (301) 966-1690

Third-party liability
Division of Operational Initiatives
Office of Program Administration (301) 966-7154
Bureau of Program Operations (301) 966-7421

Utilization
Office of Medicaid Cost Estimates
Office of the Actuary (301) 966-7914

Appendix D

Glossary of Medicare and Medicaid terms

Aid to Families with Dependent Children (AFDC)—*AFDC* is a program of income support for low-income families that was established by title IV of the Social Security Act.

Aged—For purposes of Medicare enrollment, persons 65 years of age or over are considered to be aged. Medicaid eligibility is determined on the basis of financial need for people who meet Supplemental Security Income eligibility criteria (aged, blind, or disabled individuals) and Aid to Families with Dependent Children criteria (adults and children). Eligibility determinations are made for an entire economic unit or "case" (sometimes a family) based on whether or not one member of a case meets the criteria. For example, an "aged" case could consist of a 66-year-old male and his 63-year-old wife. In contrast, a disabled enrollee could be over 65 years of age.

Assignment—An enrollee in the supplementary medical insurance program may agree with a provider of service to assign benefit rights to the provider. When this assignment method is used, the provider agrees to accept as the total charge for the covered service the amount that is approved by the carrier as the reasonable charge. The provider submits a claim to the carrier and is reimbursed for the reasonable charge, minus 20-percent coinsurance and any unmet deductible. The provider may then charge the enrollee only for the coinsurance and unmet deductible.

Automatic enrollment—Retirement and survivors insurance beneficiaries are automatically sent Medicare cards 3 months before they attain age 65; those entitled to disability benefits are automatically sent Medicare cards 3 months before the completion of 24 months of entitlement. These Medicare cards show entitlement to both hospital insurance and supplementary medical insurance (SMI). An enrollee wishing to decline SMI coverage must do so in writing no later than the month prior to the effective date of coverage.

Average compound rate of growth—Also called the average annual rate of change, this is a geometric rate of change in which increases or decreases in a variable over a span of time is treated as though the change occured at the same rate each year during the interval. For example, a variable that increased in value from 100 to 121 during a 2-year period would be said to have had an average annual rate of increase of 10 percent per year.

Benefit payments—These payments comprise all withdrawals from the Medicare hospital insurance and supplementary medical insurance trust funds for services rendered to Medicare enrollees. Payments include both reimbursements recorded on bills and payments made independently of the billing system (interim payments, end-of-year adjustments, and certain capitation payments).

Benefit period—A benefit period is the period used to limit Medicare benefits in the hospital insurance program. A benefit period begins the first day an enrollee is furnished inpatient hospital services by a qualified provider, and it ends when the enrollee has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days. There is no limit to the number of benefit periods an enrollee can have. The enrollee must pay the hospital insurance deductible for each new benefit period.

Carrier—A carrier is an organization that has contracted with the Department of Health and Human Services to process claims and perform other services under Medicare's supplementary medical insurance program.

Categorically needy—Under Medicaid, categorically needy cases are aged, blind, or disabled individuals or families and children who meet financial eligibility requirements for Aid to Families with Dependent Children, Supplemental Security Income, or an optional State supplement.

Coinsurance—Coinsurance is the portion of reimburseable hospital and medical expenses, after subtraction of any deductible, that Medicare does not cover. Under hospital insurance, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st through 90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of skilled nursing facility (SNF) care; from the 21st through 100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible. Under supplementary medical insurance (SMI), after the annual deductible has been met, Medicare pays 80 percent of reasonable charges for covered services and supplies; the remaining 20 percent of reasonable charges is the coinsurance payable by the enrollee. However, there is no coinsurance for home health services under SMI.

Copayment—Copayments are a type of cost sharing under Medicaid whereby insured or covered persons pay a specified flat amount per unit of service or unit of time, and the insurer pays the rest of the cost.

Covered services—Covered services under the Medicare program are the services and supplies for which Medicare will reimburse. Examples of covered services are given in this glossary under specific headings, such as skilled nursing facility services. Covered services under the Medicaid program consist of a combination of mandatory and optional services within each State.

Customary charge—Customary charges are the amounts physicians or suppliers usually bill patients for furnishing particular services or supplies.

Deductible—Deductibles are the amounts paid by enrollees for covered services before Medicare makes reimbursements. The hospital insurance deductible applies to each new benefit period, is determined each year by a formula specified by law, and approximates the current cost of a 1-day inpatient hospital stay. The supplementary medical insurance deductible is, by law, the first $75 of covered charges per calendar year, effective January 1, 1982.

Diagnosis-related group (DRG)—DRG groupings are a scheme for classifying inpatient patients similar in their demographic, diagnostic, and therapeutic (i.e., clinical) attributes and in the consumption of hospital resources during the inpatient stay. The amount paid for a particular DRG is based on the average costs received by hospitals with operating characteristics similar to the hospital treating the patient. The DRG is the basic unit for determining payments for hospital services under the prospective payment system.

Disabled—For purposes of Medicare enrollment, individuals under 65 years of age who have been entitled to disability benefits under the Social Security Act or the railroad retirement system for at least 24 months are considered disabled and entitled to Medicare.

Discharge—A discharge is a formal release from a hospital or skilled nursing facility. Discharges include persons who died during their stay or were transferred to another facility.

Early and periodic screening, diagnosis, and treatment (EPSDT)—The EPSDT program covers screening and diagnostic services to determine physical or mental defects in Medicaid recipients under age 21, as well as health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

End stage renal disease—Individuals who have chronic kidney disease requiring renal dialysis or a kidney transplant are considered to have end stage renal disease. To qualify for Medicare coverage, such individuals must be fully or currently insured under social security or the railroad retirement system or be the dependent of an insured person. Eligibility for Medicare coverage begins the third month after the month in which a course of renal dialysis begins. Coverage may begin sooner if the patient participates in a self-care dialysis training program provided by an approved facility. Also, coverage may begin on admittance to a hospital to receive a kidney transplant or to receive dialysis before the transplant.

Enrollment period—Effective October 1, 1981, the general enrollment period for supplementary medical insurance is from January 1 through March 31 of each year. Coverage takes effect July 1.

Expenditure—Under Medicaid, an expenditure is an amount paid for the covered medical expenses of eligible participants. (For Medicare, see "reimbursement.")

Family planning services—Family planning services are any medically approved means furnished or prescribed by or under the supervision of a physician to individuals of childbearing age for purposes of enabling such individuals freely to determine the number or spacing of their children. Diagnosis, treatment, drugs, supplies and devices, and related counseling are included.

Federal financial participation—Federal funds provided to States for expenditures made under approved State plans in accordance with the State's Federal medical assistance percentage and the administrative rate constitute Federal financial participation. The Federal share of State medical vendor payments is determined by a statutory formula designed to provide higher percentages of Federal contributions to States with low per capita incomes but lower percentages to States with higher per capita incomes.

Federal hospital insurance trust fund—The Federal hospital insurance trust fund is a trust fund of the Treasury of the United States in which are deposited monies collected from taxes on annual earnings of employees, employers, and self-employed persons covered by social security. Disbursements from the fund are made to help pay for benefit payments and administrative expenses incurred by the hospital insurance program.

Federal supplementary medical insurance trust fund—The Federal supplementary medical insurance (SMI) trust fund is a trust fund of the Treasury of the United States consisting of amounts deposited in or appropriated to the fund as provided by title XVIII of the Social Security Act, including premiums paid by enrollees under SMI and contributions by the Federal Government from general revenues. Disbursements from the fund are made for benefit payments and administrative expenses incurred by the SMI program.

Fiscal agent—A fiscal agent is a contractor that processes or pays vendor claims on behalf of the Medicaid agency. Under Medicare, fiscal agents are called intermediaries (for hospital insurance) and carriers (for supplementary medical insurance).

Fiscal year—Prior to 1977, Federal fiscal years extended from July 1 through June 30. Beginning with October 1, 1977, Federal fiscal years extended from October 1 through September 30.

General hospital—A general hospital is a hospital maintained primarily for inpatient care of acute illness or injury and for obstetrics. Health maintenance organizations and competitive medical plans have contracts with Medicare on a prospective capitation payment basis for providing health care to Medicare beneficiaries.

Health maintenance organization (HMO)—Risk HMOs and competitive medical plans have contracts with Medicare on a prospective capitation payment basis for providing health care to Medicare beneficiaries.

Home health agency—A home health agency is a public or private organization that provides skilled nursing services and other therapeutic services in the patient's home and that meets certain conditions to ensure the health and safety of the individuals receiving services.

Home health services—Home health services are services and items furnished in patients' homes under the care of physicians. These services are furnished by home health agencies or by others under arrangements made by home health agencies. Services are furnished under a plan established and periodically reviewed by a physician. The services include part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical social services; medical supplies and appliances (other than drugs and biologicals); home health aid services; and services of interns and residents.

Hospital insurance—Hospital insurance (also known as Medicare Part A) is an insurance program providing basic protection against the costs of hospital and related post-hospital services for individuals who are age 65 or over and are eligible for retirement benefits under the social security or railroad retirement systems, for individuals under age 65 who have been entitled for at least 24 months to disability benefits under the social security or railroad retirement systems, and for certain other individuals who are medically determined to have end stage renal disease and are covered by the social security or railroad retirement systems.

Independent laboratory—An independent laboratory is a laboratory certified to perform diagnostic tests independent of a physician's office or hospital and receive reimbursements from Medicare.

Inpatient hospital services—Inpatient hospital services are items and services furnished to an inpatient of a hospital by the hospital, including room and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

Intermediary—An intermediary is an organization that has an agreement with the Department of Health and Human Services (DHHS) to process claims and perform other functions under Medicare's hospital insurance program. Hospitals and skilled nursing facilities may select the intermediaries through which bills would be submitted for services to Medicare beneficiaries. Home health agencies are serviced by Regional intermediaries designated by DHHS.

Intermediate care facility—An intermediate care facility is an institution furnishing health-related care and services to individuals who do not require the degree of care provided by hospitals or skilled nursing facilities as defined under title XIX (Medicaid) of the Social Security Act.

Laboratory and radiological services—These services are professional and technical laboratory and radiological services ordered by a licensed practitioner and provided in an office or similar facility (other than a hospital outpatient department or clinic) or by a qualified laboratory.

Lifetime reserve—A Medicare hospital insurance enrollee has a nonrenewable lifetime reserve of 60 days of inpatient hospital care to draw on if the 90 covered days per benefit period are exhausted.

Long-stay hospital— A long-stay hospital is one in which the average patient stay is 30 days or more.

Medically needy—Under Medicaid, medically needy cases are aged, blind, or disabled individuals or families and children whose income resources are above the limits for eligibility as categorically needy but, after deduction of incurred medical expenses, fall within limits set under the Medicaid State plan and become eligible for Medicaid.

Other practitioners' services—Other practitioners' services are health care services of licensed practitioners other than physicians and dentists.

Outpatient hospital services—Outpatient hospital services are services furnished to outpatients by a participating hospital for diagnosis or treatment of an illness or injury.

Outpatient services—Outpatient services are medical and other services provided by a hospital or other qualified facility or supplier, such as a mental health clinic, rural health clinic, mobile X-ray unit, or freestanding dialysis unit. Such services include outpatient physical therapy services, diagnostic X-ray and laboratory tests, and X-ray and other radiation therapy.

Passthrough amounts—The Medicare payments for the medical care of patients by hospitals participating in the prospective payment system cover only operating expenses and exclude the costs of capital, direct medical education, and organ procurement. The latter costs continue to be reimbursed on a reasonable cost basis and are "passed through" directly to the hospitals on a periodic (e.g., quarterly) basis apart from the payments for the medical care of Medicare beneficiaries.

Persons served—Under Medicare, a person served is a Medicare enrollee who used a covered medical service, who incurred expenses greater than the deductible amount, and for whom Medicare paid benefits.

Physicians' services—Under Medicare and Medicaid, physicians' services are services provided by an individual licensed under State law to practice medicine or osteopathy. Services covered by hospital bills are not included.

Portable X-ray— A portable X-ray is a radiograph taken with portable equipment, usually in the patient's place of residence, under the general supervision of a physician.

Premium—A premium is a monthly fee paid by Medicare enrollees. Hospital insurance (HI) enrollees who are social security or railroad retirement beneficiaries and who qualify for coverage through age or disability are not required to pay premiums. Aged persons who are not eligible for automatic HI enrollment may pay a monthly premium to obtain HI coverage. Supplementary medical insurance enrollees pay a monthly premium that is updated annually to reflect changes in program costs.

Premium hospital insurance—Persons 65 years of age or over who are not automatically eligible for hospital insurance may obtain coverage by paying a monthly premium.

Prescribed drugs—Prescribed drugs are drugs dispensed by licensed pharmacists on the prescription of practitioners licensed by law to administer such drugs and drugs dispensed by licensed practitioners to their own patients. Drug charges that are not separable from a practitioner's other charges and drugs covered by a hospital bill are not included.

Prevailing charge—The prevailing charge is the charge at the 75th percentile in an array of the weighted customary charges made for the same service in the locality. This is the upper limit of charges deemed "reasonable" for Medicare reimbursement.

Private health plan option—Risk health maintenance organizations and competitive medical plans have contracts with Medicare on a prospective capitation basis for providing health care to Medicare beneficiaries.

Prospective payment system (PPS)—PPS is the Medicare system of payments to hospitals based on predetermined amounts for each patient discharge through the use of diagnosis-related groups (DRGs). In the aggregate, the hospital keeps the difference between the payments received from Medicare and its costs of treating Medicare patients. The hospitals are at risk for costs incurred above the prospectively determined payments, limited by additional payments for outlier cases with unusually long stays or unusually high costs.

Psychiatric hospital—A psychiatric hospital is an institution primarily engaged in providing inpatient psychiatric services for the diagnosis and treatment of mental illness by or under the supervision of a physician.

Railroad retirement system—The railroad retirement system was mandated by the Railroad Retirement Act of 1937 as a retirement system for railroad employees.

Reasonable charge—In processing claims for supplementary medical insurance benefits, carriers use Health Care Financing Administration guidelines to establish the reasonable charge for services rendered. The reasonable charge is the lowest of: the actual charge billed by the physician or supplier, the charge the physician or supplier customarily bills patients for the same service, or the prevailing charge (see previous definition of prevailing charge). Increases in physicians' prevailing charge levels are recognized by Medicare only to the extent justified by an index reflecting changes in the costs of practice and in general earnings.

Reasonable cost—Prior to the institution of the Medicare prospective payment system (PPS) for hospital services, payments to all Medicare providers were based on retrospectively determined reasonable costs. Since the institution of PPS, reasonable cost criteria are applied to skilled nursing facilities, home health agencies, and to the passthrough costs of hospitals (see previous definition of "passthrough amounts"). Reasonable cost determinations are based on criteria applied to direct and indirect costs incurred in furnishing covered services to Medicare beneficiaries and are intended to exclude costs that are unnecessary to the efficient delivery of services covered by the hospital insurance program.

Recipient—A Medicaid recipient is an individual who has been determined to be eligible for Medicaid and who has used medical services covered by Medicaid.

Reimbursement—The Medicare amount includes only the amount shown in bills received and processed by the Medicare program in the Health Care Financing Administration central office files. Interim payments to institutional providers, payments to institutional providers resulting from adjustments to the end of fiscal year cost reports, and certain capitation payments for prepaid group health plans are excluded. (For Medicaid, see "expenditure.")

Rural health clinic—A rural health clinic is an outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets certain other requirements designed to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically underserved area that is not an urbanized area as defined by the U.S. Bureau of the Census and that is designated by the Secretary of the Department of Health and Human Services either as an area with a shortage of personal health services or as a health manpower shortage area. Rural health clinics must file an agreement with the Secretary not to charge an individual for items or services for which the person is entitled to have payment made by Medicare. An individual is charged only for the amount of any applicable deductible or coinsurance amount.

Short-stay hospital—A short-stay hospital is one in which the average length of stay is less than 30 days. General and special hospitals are included in this category.

Skilled nursing facility—A skilled nursing facility is an institution that has a transfer agreement with one or more participating hospitals, is primarily engaged in providing post-hospitalization skilled nursing care and rehabilitative services to inpatients, and meets specific regulatory certification requirements.

Skilled nursing facility services—All services furnished to inpatients of a certified skilled nursing facility that meets standards required by the Secretary of the Department of Health and Human Services and billed by the facility are included.

Spend-down—Spend-down refers to a method by which an individual establishes Medicaid eligibility by reducing gross income through incurring medical expenses until net income (after medical expenses) meets Medicaid financial requirements.

State buy-in—This is the term given to the process by which a State provides supplementary medical insurance coverage for its needy eligible persons by paying their premiums through an agreement with the Federal Government.

State plan—The Medicaid State plan is a comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

Supplemental Security Income (SSI)—SSI is a program of income support for low-income aged, blind, and disabled persons that was established by title XVI of the Social Security Act.

Supplementary medical insurance (SMI)—Supplementary medical insurance (also known as Medicare Part B) is a voluntary insurance program that provides insurance benefits for physicians' and other medical services to aged and disabled individuals who elect to enroll under the program in accordance with the provisions of title XVIII of the Social Security Act. The program is financed by enrollee premium payments and contributions from funds appropriated by the Federal Government.

Third-party liability—Under Medicaid, third-party liability exists if there is any entity (including other government programs or insurance) that is liable to pay all or part of the medical cost for injury, disease, or disability of an applicant or recipient of Medicaid.

Vendor—A medical vendor is an institution, agency, organization, or individual practitioner that provides health or medical services. The term is used mostly to characterize providers of services to Medicaid recipients.

Appendix E

Medicare and Medicaid acronyms

AAPCC	Adjusted average per capita cost
ACRG	Annual compound rate of growth
AFDC	Aid to Families with Dependent Children
CRF	*Code of Federal Regulations*
CMHS	Continuous Medicare history sample
CMP	Competitive medical plan
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPR	Customary, prevailing, and reasonable
DEFRA	Deficit Reduction Act
DHHS	Department of Health and Human Services
DRG	Diagnosis-related group
EAC	Estimated acquisition cost
EPSDT	Early and periodic screening, diagnosis, and treatment
ESRD	End stage renal disease
FFP	Federal financial participation
FMAP	Federal medical assistance percentage
FSA	Family Support Act
HCFA	Health Care Financing Administration
HHA	Home health agency
HI	Hospital insurance
HMO	Health maintenance organization
ICF	Intermediate care facility
ICF/MR	Intermediate care facility for the mentally retarded
MAC	Maximum allowable cost
MMIS	Medicaid Management Information System
OACT	Office of the Actuary
OASDI	Old Age, Survivors, and Disability Insurance
OBRA	Omnibus Budget Reconciliation Act
PPS	Prospective payment system
QMB	Qualified Medicare beneficiary
SMI	Supplementary medical insurance
SNF	Skilled nursing facility
SSI	Supplemental Security Income
TEFRA	Tax Equity and Fiscal Responsibility Act

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